

# **UNIVERSITY OF CALIFORNIA**

## **Behavioral Health Benefits for Blue Cross PPO Members**

January 1, 2003



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**Schedule of Benefits**

**Effective Date of this Plan**

**January 1, 2003**

**Behavioral Health Benefits for Blue Cross PPO Members**

<b>Mental Health Member Copayments</b>		
	<b>In-Network Providers<sup>1</sup></b>	<b>Out-of-Network Providers</b>
<b>Office Visit Copayment</b>	<b>Visits 1-5: \$0</b> <b>Visits 6+: \$10*</b>	<b>Not Applicable</b>
<b>Deductibles and Out-of-Pocket Maximum</b>		
<b>Mental Health/Substance Abuse Calendar Year Deductible</b>	<b>Not Applicable</b>	<b>\$500 per person</b> <b>\$1,500 per family</b>
<b>Substance Abuse Inpatient Calendar Year Deductible</b>	<b>\$100</b>	<b>Not Applicable</b>
<b>Mental Health Out-of-Pocket Maximum</b>	<b>\$1,500 per person**</b> <b>\$4,500 per family**</b>	<b>\$6,000 per person**</b> <b>\$18,000 per family**</b>
<b>Non- preauthorization Penalty</b>	<b>Not Applicable</b>	<b>\$200<sup>5</sup></b>
<b>Percentage Payable by the Plan after Copayments/Deductibles Satisfied</b>		
<b>Mental Health Inpatient and Intermediate Care<sup>3</sup></b>	<b>100%</b>	<b>60%<sup>4</sup></b>
<b>Substance Abuse Inpatient<sup>4</sup></b>	<b>80% with Treatment Plan Compliance</b> <b>50% without Treatment Plan Compliance</b>	<b>60% with Treatment Plan Compliance</b> <b>30% without Treatment Plan Compliance</b>
<b>Mental Health Outpatient</b>	<b>100% after Copayment</b>	<b>60%</b>
<b>Substance Abuse Outpatient</b>	<b>80%</b>	<b>60%</b>
<b>Lifetime Maximum</b>	<b>None</b>	<b>\$2,000,000</b>

\*Copayment is waived for children to age six.

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

### Schedule of Benefits (continued)

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

1. In order to be a covered In-Network benefit, all services must be clinically necessary, be provided by a UBH Network Provider and be pre-approved by a UBH Intake Counselor. "UBH Network Provider" includes providers for which a case-specific accommodation is made by UBH.
2. \$100 Calendar Year Deductible applies to each Covered Person. Amounts credited to this deductible do not count toward the \$500 out-of-network deductible.
3. Preauthorization required.
4. Emergency care is treated as In-Network if UBH is notified within 48 hours of admission. Emergency care is defined as "Immediate Mental Disorder Treatment when the lack of treatment could reasonably be expected to result in the patient harming him/herself or another person(s).
5. Penalty is applied before the Covered Person accumulates covered expenses toward the individual deductible and the penalty does not apply toward the individual deductible. If the individual deductible is satisfied, the penalty is applied prior to the Plan's percentage payment of 60%. Outpatient penalty is applied per course of treatment per covered problem or condition. Inpatient penalty is applied per admission.

### Notes

- Out-of-Network outpatient mental health services are not subject to preauthorization, but must be clinically necessary to be covered and are subject to retrospective review. Expenses determined not clinically necessary will not be covered.
- The preauthorization penalty applies when preauthorization is not requested. If preauthorization is sought and not approved, no coverage is provided..
- In and Out-of-Network member expenses for Substance Abuse do not apply to the Out of Pocket Maximums.
- In-Network and Out-of-Network Annual Out of Pocket Maximums are exclusive of each other.

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## Eligibility, Enrollment and Termination Provisions

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

### Eligibility

The following individuals are eligible to enroll in this Plan. Anyone enrolled in a non University Medicare + Choice Managed Care contract is not eligible for this plan.

#### Covered Person

**Employee:** You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000 hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time\* of at least 17.5 hours per week. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

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

- (a) A month with zero regular paid hours which occurred during your furlough or approved leave without pay will not be included in the calculation of the average. If such absence exceeds eleven (11) months, the averaging will be restarted.
- (b) A month with zero regular paid hours which occurred during a period when you were not on furlough or approved leave without pay will be included in the calculation of the average. After two consecutive such months, the averaging will be restarted.

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

- (a) If you worked at least 43.75% of the regular paid hours available in the month, the month will be included in the calculation of the average.
- (b) If you did not work at least 43.75% of the regular paid hours available in the month, the month will not be included in the calculation of the average.

**Annuitant (including Survivor Annuitant):** **Annuitant** A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

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

You may continue University medical plan coverage as an Annuitant when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan, or as a Survivor Annuitant when you start collecting survivor benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

- (a) you meet the University's service credit requirements for Annuitant medical eligibility;
- (b) the effective date of your Annuitant status is within 120 calendar days of the date employment ends (or the date of the Employee/Annuitant's death for a Survivor Annuitant); and
- (c) you elect to continue medical coverage at the time of retirement.

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

### **Eligible Dependents (Family Members)**

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members. Documentation could include a marriage certificate, birth certificate(s), adoption records, or other official documentation. In addition, you will be asked to submit a copy annually of your Federal income tax return (IRS form 1040 or IRS equivalent showing the covered dependent Family Member and your signature) to the University to verify income tax dependency for those categories where it is a condition of eligibility.

**Spouse:** Your legal spouse. (Note: if you are a Survivor Annuitant, you may not enroll your legal spouse.)

**Child:** All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

- (a) your natural or legally adopted children;
- (b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
- (c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
- (d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental handicap may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous,
- the child is dependent on you for at least 50% of his or her support and is your dependent for income tax purposes, and
- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan 31 days before the child's 23<sup>rd</sup> birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

**Other Eligible Dependents (Family Members)** You may enroll an adult dependent relative or same-sex domestic partner (and the same-sex domestic partner's children/grandchildren) as set forth in the University of California's Group Insurance Regulations. For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center.

## No Dual Coverage

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

## Enrollment

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are an Annuitant, contact the University's Customer Service Center. Enrollment transactions may be by paper form or electronic, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

## During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan you are enrolled in.

- (a) For a spouse, on the date of marriage. Survivor Annuitants may not add Spouses to their coverage.
- (b) For a natural child, on the child's date of birth.
- (c) For an adopted child, the earlier of:
  - (i) the date you or your Spouse has the legal right to control the child's health care, or
  - (ii) the date the child is placed in your physical custody.If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.
- (d) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other group medical plan coverage and you lose that coverage involuntarily, you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

## At Other Times

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

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

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



If you are an Annuitant, you may continue coverage for yourself and your enrolled Family Members in the same plan you were enrolled in immediately before retiring. You must elect to continue enrollment before the effective date of retirement (or the date disability or survivor benefits begin).

#### **Effective Date**

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are an Annuitant continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91<sup>st</sup> consecutive calendar day after the date the enrollment transaction is completed.

When you already have two or more Family Members enrolled and enroll another Family Member, coverage may be retroactive with the effective date limited to the later of:

- (a) the date the newly added Family Member becomes eligible, or
- (b) a maximum of 60 days prior to the date his or her enrollment transaction is completed.

#### **Change in Coverage**

In order to change from individual to two-party coverage and from two-party to family coverage, or to add another Family Member to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are an Annuitant).

#### **Effect of Medicare on Annuitant Enrollment**

If you are an Annuitant and you and/or an enrolled Family Member is or becomes eligible for premium free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's non-University employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Annuitants and their Family Members who are eligible for premium free Medicare Part A, but decline to enroll in Part B of Medicare, will be assessed a monthly offset fee by the University to cover increased costs. Annuitants or Family Members who are not eligible for Part A will not be assessed an offset fee. A notarized affidavit attesting to their ineligibility for Medicare Part A will be required. Affidavits may be obtained from the University's Customer Service Center. (Annuitants/Family Members who are not entitled to Social Security and Medicare Part A will not be required to enroll in Part B.)

You should contact Social Security three months before your or your Family Member's 65<sup>th</sup> birthday to inquire about your eligibility and how you enroll in the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration forms are available through the University's Customer Service Center. Completed forms should be returned to the Annuitant Insurance unit at Office of the President.

## **Medicare Private Contracting Provision**

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

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

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

## **Termination Of Coverage**

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

### **Deenrollment Due to Loss of Eligible Status**

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If you are an Annuitant or Survivor Annuitant and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are an Annuitant).

### **Deenrollment Due to Fraud**

Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Covered Person (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be permanently deenrolled while any other Family Member and the Covered Person will be deenrolled for 18 months. If a Covered Person commits fraud or deception, the Covered Person and any Family Members will be deenrolled for 18 months.

### **Leave of Absence, Layoff or Retirement**

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

### **Optional Continuation of Coverage**

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the UCbencom website ([www.ucop.edu/bencom](http://www.ucop.edu/bencom)). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are an Annuitant.

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## **Behavioral Health Benefits**

### **What This Plan Pays**

**Behavioral Health Benefits are payable for Covered Expenses incurred by a Covered Person for Behavioral Health Services received from either Network or Non-Network Providers.**

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

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

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

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

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

**Behavioral Health Services are services and supplies which are:**

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

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

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

### **Telemedicine**

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

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

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

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

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

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

#### Notification Requirements and Utilization Review

Except for Emergency Care, to receive the higher level of benefits under this Plan (called the Network level) and not incur the penalties shown below, the Covered Person must call United Behavioral Health (UBH) before inpatient Behavioral Health Services are given. The toll-free number is 1-888-440-UCAL (8225). UBH is ready to take the Covered Person's call 7 days a week, 24 hours a day. This call starts the Utilization Review process. The Covered Person will be referred to a Network Provider who is experienced in addressing his/her specific issues.

Benefits under this Plan are reduced as follows if the Covered Person does not get a referral from UBH to a UBH Network Provider before inpatient Behavioral Health Services are given:

- Benefits are payable at the Non-Network level, as shown in Schedule of Benefits.
- Benefits are subject to a Non-authorization Penalty. The amount of the Non-authorization Penalty will never be more than the Covered Expense. The amount is shown in Schedule of Benefits.
- Benefits are subject to Utilization Review at the time a claim is submitted for payment in order to determine if the services incurred meet the Clinical Necessity criteria for Behavioral Health Services.

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

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

#### Appeals

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

#### Emergency Care

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

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

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

## **Copayments and Deductibles**

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

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

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

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

### **Mental Health Office Visit Copayment**

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

### **Substance Abuse Inpatient and Intermediate Care Calendar Year Deductible**

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

### **Out-of-Pocket Feature**

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

### **Individual Mental Health Out-of-Pocket Maximum**

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

### **Family Mental Health Out-of-Pocket Maximum**

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

### **Out-of-Network Calendar Year Deductible**

The Out-of-Network Calendar Year Deductible applies to all Out-of-Network charges for services or supplies given in connection with any Out-of-Network Service each Calendar Year.

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## **Not Covered**

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

- Services or supplies which are not Clinically Necessary, including any confinement or treatment given in connection with a service or supply which is not Clinically Necessary.
- Services or supplies received before the Covered Person becomes covered under this Plan.
- Expenses incurred by a Dependent if the Dependent is covered as an Employee or Annuitant for the same services under this Plan.
- Treatment given in connection with any of the following diagnoses: mental retardation (except initial diagnosis), chronic organic brain syndrome, or learning disability.

- Surgery, hormone replacement or any medically related procedure pertaining to transsexualism.
- Completion of claim forms or missed appointments.
- Custodial Care that has not been approved by UBH. This is care made up of services and supplies that meets one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
  - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

Care that meets one of the conditions above is custodial care regardless of any of the following:

- Who recommends, provides or directs the care.
- Where the care is provided.
- Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.
- Ecological or environmental medicine, diagnosis and/or treatment.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Services, supplies, medical care or treatment given by one of the following members of the Employee's/Annuitant's immediate family:
  - The Employee's/Annuitant's spouse, Same-sex Domestic Partner, or Adult Dependent Relatives.
  - The child, brother, sister, parent or grandparent of either the Employee/Annuitant or the Employee's/Annuitant's spouse.
- Services or supplies, treatments or drugs which are considered investigational because they do not meet generally accepted standards of medical practice in the United States. This includes any related confinements, treatment, service or supplies.
- Services and supplies for which the Covered Person is not legally required to pay.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Nutritional counseling.
- Occupational injury or sickness - an occupational injury or sickness is an injury or sickness which is covered under a workers' compensation act or similar law. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Behavioral Health Services.
- Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-Clinically Necessary purposes, and related expenses for reports, including report presentation and preparation.
- Services given by a pastoral counselor.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners humidifiers, saunas, hot tubs.
- Private duty nursing services while confined in a facility.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Sex-change surgery.
- Stand-by services required by a Physician.

- Telephone consultations.
- Tobacco dependency.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Weight reduction or control (unless there is a diagnosis of morbid obesity), special foods, food supplements, liquid diets, diet plans or any related products.
- Services given by volunteers or persons who do not normally charge for their services.

#### Network Provider Charges Not Covered

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

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

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

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#### Claims Information

##### How to File a Claim

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

The following steps should be completed when submitting bills for payment for services and supplies received from Out-of-Network providers:

- Get a claim form from United Behavioral Health.
- Complete the Employee/Annuitant portion of the form.
- Have the provider complete the provider portion of the form.
- Send the form and bills to the address shown on the form.

All payments for services and supplies received outside of the United States will be paid directly to the Employee/Annuitant, unless the Employee/Annuitant requests in writing that payments be made directly to the provider. An Employee/Annuitant does this when completing a claim form. The following steps should be completed when submitting bills for payment for services and supplies received outside the United States:

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

- The Employee/Annuitant's name, Social Security Number, address and phone number.
- The patients's name.
- The Plan number (11280).
- The name, address and phone number of the provider.
- The licensure of the provider.
- The date of service.

- The place of service.
- The specific services provided.
- The amount charged for the service.
- The diagnosis.

The claim/billing statement should be mailed to:

United Behavioral Health  
P.O. Box 744925  
Houston, TX 77274-4925

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

#### When Claims Must be Filed

The Covered Person must give the Company written proof of loss within 15 months after the date the expenses are incurred.

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

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

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

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

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

#### Benefit Determinations

##### Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving Behavioral Health Services. If the Covered Person's claim was a pre-service claim, and was submitted properly with all needed information, the Covered Person will receive written notice of the claim decision from UBH within 15 days of receipt of the claim. If the Covered Person filed a pre-service claim improperly, UBH will notify the Covered Person of the improper filing and how to correct it within five days after the pre-service claim was received. If additional information is needed to process the pre-service claim, UBH will notify the Covered Person of the information needed within 15 days after the claim was received, and may request a one-time extension not longer than 15 days and pend the Covered Person's claim until all information is received. Once notified of the extension, the Covered Person then has 45 days to provide this information. If all of the needed information is received within the 45-day time frame, UBH will notify the Covered Person of the determination within 15 days after the information is received. If the Covered Person does not provide the needed information within the 45-day period, the claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.



## **Concurrent Care Claims**

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the request to extend the treatment is an urgent claim as defined below, the Covered Person's request will be decided upon within 24 hours, provided the request is made at least 24 hours prior to the end of the approved treatment. UBH will make a determination on the request for the extended treatment within 24 hours from receipt of the request. If the request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent claim and decided according to the timeframes described below.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and the Covered Person's request to extend treatment is a non-urgent circumstance, the request will be considered a new claim and decided according to pre-service or post-service timeframes, whichever applies.

## **Post-service Claims**

Post-service claims are those claims that are filed for payment of benefits after Behavioral Health Services have been received. If the Covered Person's post-service claim is denied, he or she will receive a written notice from UBH within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UBH will notify the Covered Person within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend the claim until all information is received.

Once notified of the extension, the Covered Person then has 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, UBH will notify the Covered Person of the denial within 15 days after the information is received. If the Covered Person does not provide the needed information within the 45-day period, his or her claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

## **Urgent Claims that Require Immediate Attention**

Urgent claims are those Emergency Care claims that require notification or a benefit determination prior to receiving Mental Disorder Treatment. In these situations:

- The Covered Person will receive notice of the benefit determination in writing or electronically within 72 hours after UBH receives all necessary information, taking into account the seriousness of the Covered Person's condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If the Covered Person files an urgent claim improperly, UBH will notify the Covered Person of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, UBH will notify the Covered Person of the information needed within 24 hours after the claim was received. The Covered Person then has 48 hours to provide the requested information.

The Covered Person will be notified of a benefit determination no later than 48 hours after:

- UBH's receipt of the requested information; or
- The end of the 48-hour period which the Covered Person was given to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

## Questions or Concerns about Benefit Determinations

If the Covered Person has a question or concern about a benefit determination, he or she may informally contact UBH's customer service department before requesting a formal appeal. If the Covered Person is not satisfied with a benefit determination as described above, he or she may appeal it as described below, without first informally contacting a customer service representative. If the Covered Person first informally contacted UBH's customer service department and later wishes to request a formal appeal in writing, the Covered Person should again contact customer service and request an appeal. If the Covered Person requests a formal appeal, a customer service representative will provide the Covered Person with the appropriate address.

If the Covered Person is appealing an urgent claim denial, please refer to the *Urgent Claim Appeals that Require Immediate Action* section below and contact UBH's Appeals Unit immediately.

## How to Appeal a Claim Decision

If the Covered Person disagrees with a claim determination after following the above steps, he or she can contact UBH in writing to formally request an appeal. If the appeal relates to a claim for payment, the request should include:

- The patient's name and the identification number.
- The date(s) of service(s).
- The provider's name.
- The reason the Covered Person believes the claim should be paid.
- Any documentation or other written information to support the request for claim payment.

The Covered Person's first level appeal request must be submitted to UBH within 180 days after he or she receives a claim denial.

## Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If the appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. UBH may consult with, or seek the participation of, medical experts as part of the appeal resolution process. The Covered Person consents to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, the Covered Person has the right to reasonable access to and copies of all documents, records, and other information relevant to his or her claim for benefits.

## Appeals Determinations

### First Level Pre-service and Post-service Claim Appeals

The Covered Person will be provided written or electronic notification of the decision on the appeal as follows:

For appeals of pre-service claims as identified above, the first level appeal will be conducted and the Covered Person will be notified of the decision within 15 days from receipt of a request for appeal of a denied claim.

For appeals of post-service claims as identified above, the first level appeal will be conducted and the Covered Person will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim.

For procedures associated with urgent claims, see *Urgent Claim Appeals That Require Immediate Action* below.

If the Covered Person is not satisfied with the first level appeal decision, he or she has the right to request a second level appeal, see *Second Level Pre-service and Post-service Claim Appeals* below.

Please note that UBH's decision is based only on whether or not benefits are available under the policy for the proposed treatment or procedure.

## **Second Level Pre-service and Post-service Claim Appeals**

If the Covered Person is not satisfied with the first level appeal decision. The Covered Person has the right to request a second level appeal. The second level appeal request must be submitted to UBH within 60 days from receipt of the first level appeal decision.

For appeals of pre-service claims, the second level appeal will be conducted and the Covered Person will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims, the second level appeal will be conducted and the Covered Person will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

## **Urgent Claim Appeals that Require Immediate Action**

An appeal may require immediate action if a delay in treatment could significantly increase the risk to the Covered Person's health, or the ability to regain maximum function. In these urgent situations:

The appeal does not need to be submitted in writing. The Covered Person or his or her Physician should call UBH as soon as possible.

UBH will provide the Covered Person with a written or electronic determination within 72 hours following receipt of the request for review of the determination, taking into account the seriousness of the Covered Person's condition.

## **Legal Actions**

The Covered Person may not sue on a claim before the Covered Person has exhausted UBH's internal appeals process. The Covered Person may not sue after three years from the time proof of loss is required, unless the law in the area where the Covered Person lives allows for a longer period of time.

## **Incontestability of Coverage**

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

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

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## **Coordination of Benefits**

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

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

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

## Definitions

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

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

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

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

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

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

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

## How Coordination Works

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

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

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

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

## Which Plan Pays First

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

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:
  - Medicare is secondary to the plan covering the person as a dependent.
  - Medicare is primary to the plan covering the person as other than a dependent (example, an Annuitant).

- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

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

If the other plan does not have a birthday rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

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

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

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

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

#### **Medicare Coordination**

Medicare benefits are primary and then the benefits of this plan are calculated on Medicare allowance, less Medicare payment. Benefits not covered by Medicare, but covered by the Plan will be reimbursed at 80% of customary and reasonable charges.

For non-Medicare covered expenses, the benefits of this plan may be reduced if the Covered Person has any other group health, dental, prescription drug or vision coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

#### **Right to Exchange Information**

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

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

## Facility of Payment

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

## Right of Recovery

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

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

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## Recovery Provisions

### Refund of Overpayments

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

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

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

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

### Reimbursement of Benefits Paid

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

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

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

### Subrogation

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

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

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

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## Plan Administration

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Hospital and Professional Service Agreement. What is written in this document does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

### Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in your Booklet-Certificate. If you have a question, you may direct it to:

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

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

### Mental Health & Substance Abuse Benefits

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

United Behavioral Health  
P.O. Box 744925  
Houston, TX 77274-4925  
(888) 440-8225

### Group Policy Number

11280

### Type of Plan

This Plan is a health and welfare plan that provides group health care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

### Plan Year

The plan year is January 1 through December 31.

## Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. *Plan benefits are not accrued or vested benefit entitlements.* The right to terminate or amend applies to all Employees, Annuitants and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

## Financial Arrangements

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

## Agent for Serving of Legal Process

Legal process may be served on the Plan Administrator or on the plan claim processor at the address listed above.

## Your Rights under the Plan

As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, or instead of or in addition to, at other locations that may be specified by the Plan Administrator, all Plan documents, including insurance contracts.
- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

## Mental Health/Substance Abuse Claims

Network claims under United Behavioral Health's Mental Health/Substance Abuse Benefit are filed by the United Behavioral Health provider. To file an Out-of-Network claim or appeal a denied Out-of-Network claim, refer to pages 12-16.

## Nondiscrimination Statement

In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director Mattie Williams at: University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612; and for faculty to Executive Director Sheila O'Rourke, at this address: University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

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## Glossary

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

### Annuitant

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



### **Calendar Year**

A period of one year beginning with January 1.

### **Covered Person**

Please refer to pages 3-4 of this document for the definition of Covered Person.

### **Course of Treatment**

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

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

### **Emergency Care**

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

### **Employee**

Please refer to page 3 of this document for the definition of Employee.

### **Health Care Provider**

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

### **Hospital**

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

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

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

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

### **Intermediate Care**

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

### **Licensed Counselor**

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

### **Medicare**

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

### **Mental Disorder Treatment**

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

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

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

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

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

Prescription Drugs are not considered Mental Disorder Treatment.

### **Network Provider**

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

### **Non-Network Provider**

A provider which does not participate in the network.

### **Physician**

A legally qualified:

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

### **Plan**

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

### **Psychologist**

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

- A person licensed or certified as a psychologist.

- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

#### **Reasonable Charge**

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

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

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

#### **Registered Nurse**

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

#### **Substance Abuse Rehabilitation**

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

#### **Treatment Center**

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

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

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

**Treatment Plan Compliance**

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

**Utilization Review**

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

**End of Certificate**

**IMPORTANT NOTICE**

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

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

**CALL THE CALIFORNIA DEPARTMENT OF INSURANCE AT:**

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

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

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

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