

UNIVERSITY OF CALIFORNIA

Behavioral Health Benefits for Kaiser Permanente – California Members

Combined Evidence of Coverage / Disclosure Form

**U.S. Behavioral Health Plan, California
(The “Plan” or USBHPC)**

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Introduction

WELCOME TO U.S. BEHAVIORAL HEALTH PLAN, CALIFORNIA

Note: U.S. Behavioral Health Plan, California is the formal legal name of the entity providing Behavioral Health Care benefits. It operates using the brand name OptumHealth Behavioral Solutions of California. If you see documents labeled or referencing OptumHealth Behavioral Solutions of California, those refer to U.S. Behavioral Health Plan, California.

This *Combined Evidence of Coverage and Disclosure Form* will help you become more familiar with Behavioral Health Care benefits covered by USBHPC. It is a legal document that explains the Behavioral Health benefits and should answer many important questions about these benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see the **Glossary** in this Combined Evidence of Coverage and Disclosure Form.

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the plan. The plan contract must be consulted to determine the exact terms and conditions of coverage.

Whether you are the employee under this coverage or enrolled as a family member, your *Combined Evidence of Coverage and Disclosure Form* is a key to making the most of your membership, and it should be read completely and carefully. All applicants have a right to view this document prior to enrollment. Individuals with special behavioral health needs should carefully read those sections that apply to them.

This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

What if I still need help?

After you become familiar with your behavioral health benefits, you may still need assistance. Please do not hesitate to call our Customer Service Department at 1-888-440-8225, or for the hearing and speech impaired dial 711 and at the operator's request, say or enter "1-888-440-8225".

You may write to USBHPC at the following address:

U.S. Behavioral Health Plan, California
425 Market Street, 14th Floor
San Francisco, CA 94105
Or visit USBHPC's Web site:
www.liveandworkwell.com

Important Language Information:

You may be entitled to the following rights and services. These rights apply under California law. These rights shall be available in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services.

You can get an interpreter in any of the top 15 languages spoken by limited English-proficient individuals at no cost to help you talk with your provider or health plan. USBHPC uses a telephone translation service for almost 140 languages and dialects. In addition to Customer Service representatives who are fluent in Spanish, translated Member materials are available upon request. Interpretation services are available at no charge to the member in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services. To get help in your language, please call your health plan at: U.S. Behavioral Health Plan, California at 1-888-440-8225 / TTY: 711. These services are available at no cost to you when filing a grievance with the Plan.

Language services and the availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, will be at no charge and provided in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities. For further assistance, please contact USBHPC at 888-440-8225.

If you need more help, call DMHC Help Center at 1-888-466-2219.

Timely Access to Care

USBHPC has established the following standards to ensure Members are able to obtain covered treatment in a timely manner.

Non-Life-Threatening Emergency (A situation in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm to self or others): Members must be offered an appointment **within six (6) hours** of the request for the appointment.

Urgent (A situation in which immediate care is not needed for stabilization but, if not addressed in a timely way, could escalate to an emergency situation): Members must be offered an appointment **within 48 hours** of the request for the appointment.

Routine (non-urgent) (A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others): Members must be offered an appointment **within ten (10) business days** of the request for the appointment.

Telephone wait times: USBHPC ensures that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and that the triage or screening waiting time does not exceed **thirty (30) minutes**. Telephone triage or screening services are available 24 hours per day, 7 days per week (Title 28, California Code of Regulations, Section 1300.67.2.2 (c)(8)(a)).

NOTE: The time for a particular, non-emergency appointment may be extended if it is determined and documented that a longer waiting time will not have a detrimental impact on the Member's health. Rescheduling of appointments, when necessary, must be consistent with good professional care and ensure there is no detriment to the Member.

- USBHPC expects all Participating Providers to return calls to Members within 24 hours.
- Interpreter services are available to Members at the time of the appointment if requested by the Member or provider. To request interpreter services contact USBHPC at 888-440-8225. Language interpretation services are available at no cost to the Member.

USBHPC is committed to offering medically necessary and appropriate and timely access to care pursuant to Section 1367.031 of the California Health and Safety Code. If you are unable to obtain a timely referral to an appropriate

provider, you may contact USBHPC for assistance by calling 1-888-440-8225. Additionally, the DMHC Help Center may be contacted at 1-888-466-2219 to file a complaint if you are unable to obtain a timely referral to an appropriate Participating Provider.

Choice of Physicians and Providers

USBHPC's Participating Providers include hospitals, group practices and licensed behavioral health professionals, which include psychiatrists, psychologists, social workers, marriage and family therapists, and nurse practitioners. All Participating Providers are carefully screened and must meet strict USBHPC licensing and program standards.

Call the USBHPC Customer Service Department for:

- Information on USBHPC Participating Providers,
- Provider office hours,
- Background information such as their areas of specialization,
- A copy of our *Provider Directory*.

Every contract between USBHPC and a Participating Provider provides that in the event USBHPC fails to pay the provider, the member shall not be liable to the provider for any sums owed by USBHPC.

Facilities

Along with listing our Participating Providers, your USBHPC Participating Provider Directory has detailed information about our Participating Providers. This includes a QUALITY INDEX® for helping you become familiar with our Participating Providers. If you need a copy or would like assistance picking your Participating Provider, please call our Customer Service Department. You can also find an online version of the USBHPC Participating Provider Directory at www.liveandworkwell.com.

Non-Participating Providers

If you choose to see a provider who is not part of the USBHPC participating provider network, the services will be excluded, and you will have to pay for the entire cost of the treatment (except in the case of an Emergency) with no reimbursement from USBHPC.

NOTICE OF NON-DISCRIMINATION

The Plan does not exclude, deny Covered Services to, or otherwise discriminate against any Member on the ground of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability for participation in, or receipt of the Covered Services under, any of its Health Plans, whether carried out by the Plan directly or through a Network Medical Group or any other entity with which the Plan arranges to carry out Covered Services under any of its Health Plans.

This statement is in agreement with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued according to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

If you think you were discriminated against, you may file a grievance with the plan and, if not resolved, you can file a grievance with the Department of Managed Healthcare ("DMHC"). For filing a grievance, please refer to the section of this certificate called, "What to do if you have a problem".

If you think you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can file a complaint with the U.S. Department of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

Compensating Participating Providers

USBHPC itself is not a Provider of Behavioral Health Services. USBHPC typically contracts with independent providers to provide Behavioral health Services to its Members and with hospitals to provide hospital services. Once they are contracted they become USBHPC Participating Providers. USBHPC's network of Participating Providers includes individual practitioners, group practices and facilities.

USBHPC Participating Providers who are groups, or facilities may in turn employ or contract with individual psychiatrists, psychologists or other licensed behavioral health professionals. None of the Participating Providers or their employees is an employee or agent of USBHPC. Likewise, neither USBHPC nor any employee of USBHPC is an employee or agent of any Participating Provider.

Our USBHPC Participating Providers are paid on a discounted fee-for-service basis for the services they provide. They have agreed to provide services to you at the normal fee they charge, minus a discount. USBHPC does not compensate nor does it provide any financial bonuses or any other incentives to its providers based on their utilization patterns.

If you would like to know more about fee-for-service reimbursement, you may request additional information from the USBHPC Customer Service Department or your USBHPC Participating Provider.

Confidentiality of Information

USBHPC takes the subject of Member confidentiality very seriously and takes great measures to protect the confidentiality of all member information in its possession, including the protection of treatment records and personal information. USBHPC provides information only to the professionals delivering your treatment or as otherwise required by law.

Confidentiality is built into the operations of USBHPC through a system of control and security that protects both 7

A statement describing USBHPC's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you open request. If you would like a copy of USBHPC's confidentiality policies and procedures, you may call our Customer Service Department at 1-888-440-8225.

USBHPC Public Policy Participation

USBHPC affords its members the opportunity to participate in establishing its public policy. For the purpose of this paragraph, "public policy" means acts performed by USBHPC and its employees to assure the comfort, dignity and convenience of Members who rely on Participating Providers to provide Covered Services. USBHPC members comprise at least 51% of USBHPC's public policy committee. If you are interested in participating in USBHPC's public policy committee, please call the USBHPC Customer Service Department for more details.

Schedule of Benefits

(Note: Words in **bold** print are either reference to sections within the Evidence of Coverage (EOC) /Disclosure Form or defined in the **Glossary** at the end of this EOC.)

Effective Date of this Plan January 1, 2020

Behavioral Health Benefits for Kaiser Permanente California Non-Medicare Members

Covered Services	Participating Providers Member Cost Sharing
CALENDAR YEAR DEDUCTIBLE	
Individual	\$0
Family	\$0
ANNUAL OUT-OF-POCKET MAXIMUMS (INCLUDES DEDUCTIBLES)²	
Individual	\$1,000
Family	\$3,000
ANNUAL BENEFIT MAXIMUMS	
Mental Health	None
Substance Abuse	None
LIFETIME BENEFIT MAXIMUMS	
Mental Health	None
Substance Abuse	None
MENTAL HEALTH / SUBSTANCE USE	
Routine Outpatient Visits³	
Visits 1-3	No copay
Visits 4+	\$20 copay
Non-Routine Outpatient Visits⁴	
Psychological Testing, Outpatient Electro-convulsive therapy, extended length therapy sessions, biofeedback, Applied Behavior Analysis, methadone maintenance	Visits 1-3 No copay Visits 4+ \$20 copay
Structured/Intensive outpatient program treatment	No copay
Partial Hospitalization/Day treatment	No copay
Inpatient Treatment⁵	\$250 copay per admission/ course of treatment
Emergency Services and Care⁶	
Outpatient Hospital Emergency Room Services	\$75 copay (waived if admitted)
Ambulance	No copay

¹ To be covered, services must be Medically Necessary and provided by a USBHPC Participating provider. Covered services other than Routine Outpatient Treatment and emergency treatment must be preauthorized (see "Preauthorization Requirement and Utilization Review" section in the Combined Evidence of Coverage and Disclosure Form for further information) in order to be covered. If treatment requiring preauthorization is not preauthorized, it will not be covered. ² Kaiser members use covered Mental Health and Substance Use expenses incurred under this plan to satisfy the Annual Out-of-Pocket Maximum shown in this Schedule of Benefits. Note:

Mental health and substance abuse coverage is provided under this plan to Kaiser members as supplemental coverage and, hence, is not necessarily provided in parity with Kaiser's medical/surgical coverage.

³ Outpatient includes Routine Outpatient Treatment, which are individual, family, and group counseling sessions up to 50 minutes and medication management visits with a mental health and substance abuse professional.

⁴ Outpatient also includes Non-Routine Treatment such as psychological testing, outpatient electro-convulsive therapy (ECT), extended length therapy sessions, biofeedback, treatment planning, behavioral health treatment for pervasive developmental disorders and autism, Structured/Intensive Outpatient Program treatment, Partial Hospitalization / Day treatment and methadone maintenance. These services require preauthorization in order to be covered.

⁵ Inpatient Treatment includes Hospital/Facility-based treatment such as Acute Inpatient, Detoxification services, Residential treatment, or Recovery Home treatment. These services require preauthorization in order to be covered. The copayment for an Inpatient admission includes any related Inpatient Professional Services.

⁶ USBHPC will cover Emergency Services and Care services regardless of the Provider's contract status with USBHPC. USBHPC will reimburse these Covered Expenses to ensure the member's liability is limited to the cost-share (e.g. copayment or coinsurance) of a participating provider. Emergency Services and Care is defined as an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, within the capability of the facility. The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital or to an acute psychiatric hospital.

Note

- Mental health/substance abuse claims for **Emergency Services and Care** with non-participating providers should be submitted online at www.liveandworkwell.com; if that is not possible, claims can be submitted on paper to:

Optum Claims, P.O. Box 30760, Salt Lake City, UT 84130-0760

Eligibility, Enrollment and Termination Provisions

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

USBHPC Members

There are two kinds of USBHPC Members: Subscribers and enrolled Family Members (also called Dependents). The Subscriber is the person who enrolls through the University-sponsored health benefit plan. The University has signed a Group Agreement with USBHPC.

The following Family Members are eligible to enroll in USBHPC:

1. The Subscriber's legal spouse or Domestic Partner;
2. The biological children of the Subscriber or the Subscriber's legal spouse or the Domestic Partner (stepchildren) who are under the Limiting Age established by the University;
3. Children who are legally adopted or placed for adoption with the Subscriber, the Subscriber's legal spouse or the Domestic Partner who are under the Limiting Age established by the employer;
4. Children for whom the Subscriber, the Subscriber's legal spouse or Domestic Partner has assumed permanent legal guardianship. Legal evidence of the guardianship, such as a certified copy of a court order, must be provided to USBHPC upon request; and
5. Children for whom the Subscriber, the Subscriber's legal spouse or Domestic Partner is required to provide health insurance coverage according to a qualified medical child support order assignment order, or medical support order, in this section.
6. Any child for whom the Subscriber has assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by intentional assumption of parental status, or assumption of parental duties by the Subscriber, as certified by the Subscriber at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled. Your Dependent children cannot be denied enrollment and eligibility due to the following:
 - Was born to a single person or unmarried couple;
 - Is not claimed as a Dependent on a federal income tax return;
 - Does not reside with the Subscriber or within the USBHPC Service Area.

Eligibility for Coverage

All Members must meet all eligibility requirements established by the University and USBHPC. USBHPC's Member eligibility requirements are:

- The Member must have a primary residence or primary workplace within the USBHPC Plan Service Area; and
- The Member must meet any other eligibility requirements established by the University, such as exhaustion of a waiting period before an Eligible Employee can enroll in USBHPC. The University will also establish the Limiting Age, the age limit for providing coverage to children.

Eligible Family Members must enroll under this USBHPC Behavioral Health Plan at the same time as the Subscriber or risk not being eligible to enroll until the University's next Open Enrollment Period, as explained below. Circumstances which allow for enrollment outside the Open Enrollment Period are also explained below. All applicants for coverage must complete and submit to USBHPC all applications or other forms or statements that USBHPC may reasonably request.

Enrollment is the completion of a USBHPC enrollment form (or a nonstandard enrollment form approved by USBHPC) by the Subscriber on his or her own behalf or on the behalf of any eligible Family Member. Enrollment is conditional upon acceptance by USBHPC, the existence of a valid Employer Group Agreement, and the timely payment of applicable Plan Premiums. USBHPC may, in its discretion and subject to specific protocols, accept enrollment data through an electronic submission.

Effective Date of Coverage for New Subscribers and Family Members to be added outside the Open Enrollment Period

Coverage for a newly enrolled Subscriber and his or her eligible Family Members begins on the date agreed to by the University or under the terms of the signed Group Agreement provided USBHPC receives the completed enrollment form and any required Premium within 30 days of the date the Subscriber becomes eligible to enroll in the Plan.

The effective date of enrollment when adding Family Members outside of the initial, Special, or Open Enrollment Period is explained below.

Open Enrollment

Most Members enroll in USBHPC during the Open Enrollment Period established by the University. This is the period of time established by the University when its Eligible Employees and their eligible Family Members may enroll in the employer's health benefit plan.

Adding Family Members to your Coverage

The Subscriber's legal spouse or Domestic Partner and eligible children may apply for coverage with USBHPC during the University's Open Enrollment Period. If you are declining enrollment for yourself or your Dependents (including your legal spouse or Domestic Partner) because of other Behavioral Health Plan insurance or group Behavioral Health Plan coverage, you may be able to enroll yourself and your Dependents in USBHPC if you and your Dependents lose eligibility for that other coverage (or if the University stops contributing toward your and your Dependents other coverage). However, you must request enrollment within 60 days after your or your Dependent's other coverage ends (or after the University stops contributing toward your or your Dependent's other coverage). In addition, if you have a new Dependent due to assumption of a part-child relationship, marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, assumption of a parent-child relationship or placement for adoption. (Guardianship is not a qualifying event for other Family Members to enroll.) New Family Members may be added outside the Open Enrollment Period if they meet any of the following. To obtain more information, call the USBHPC Customer Service department.

Family Members are invited to enroll in the USBHPC Behavioral Health Plan, as long as they meet the University's eligibility requirements. Please note that you may be asked to provide a marriage certificate, affidavit of domestic partnership, birth certificate or legal adoption paperwork. If you:

1. **Getting married.** When a new legal Spouse or child becomes an eligible Family Member as a result of marriage, coverage begins on the date of the marriage if we receive a completed application to enroll a legal spouse or child eligible due to marriage within 60 days of the marriage.
2. **Domestic Partnership.** When a new Domestic Partner or Domestic Partner's child becomes an eligible Family Member as a result of a domestic partnership, coverage begins on the date of the domestic partnership. An application to enroll a Domestic Partner or child eligible as a result of a domestic partnership must be made within 60 days of the domestic partnership.
3. **Having a baby.** Newborns are covered for the first 60 days of life. In order for coverage to continue beyond the first 60 days of life, a Change Request Form must be submitted to USBHPC prior to the expiration of the 60-

day period. If you do not enroll the newborn child within 60 days, the newborn is covered for only 31 days (including the date of birth).

4. Adoption or Placement for Adoption. Subscriber may enroll an adopted child if Subscriber obtains an adoptive placement from a recognized county or private agency, or if the child was adopted as documented by a health Facility minor release form, a medical authorization or a relinquishment form, granting Subscriber, Subscriber's legal spouse or Domestic Partner the right to control the health care for the adoptive child or absent such a document, on the date there exists evidence of the Subscriber's legal spouse's or Domestic Partner's right to control the health care of the child placed for adoption. For adopted children, coverage is effective on the date of adoption or placement for adoption. An application must be received within 60 days of the adoption placement.

5. Assumption of a Parent-Child Relationship or Guardianship. To enroll a Dependent child for whom the Subscriber, a Subscriber's legal spouse or Domestic Partner has assumed legal guardianship or assumption of a parent-child relationship, the Subscriber must submit a Change Request Form to USBHPC and for legal guardianship, a certified copy of a court order granting guardianship within 60 days of when the Subscriber, Subscriber's legal spouse or Domestic Partner assumed legal guardianship. Coverage will be retroactively effective to the date the Subscriber assumed legal guardianship or a parent-child relationship.

Qualified Medical Child Support Order

A Member (or a person otherwise eligible to enroll in the USBHPC Behavioral Health Plan) may enroll a child who is eligible to enroll in the USBHPC Behavioral Health Plan upon presentation of a request by a District Attorney, State Department of Health Services or a court order to provide medical support for such a Dependent child without regard to any enrollment period limitations.

A person having legal custody of a child or a custodial parent who is not a USBHPC Member may ask about obtaining Dependent coverage as required by a court or administrative order, including a Qualified Medical Child Support Order, by calling USBHPC's Customer Service Department. A copy of the court or administrative order must be included with the enrollment application. Information including, but not limited to, *Combined Evidence of Coverage and Disclosure Form* or other available information, including notice of termination, will be provided to the custodial parent, caretaker and/or District Attorney. Coverage will begin on the date of the court or administrative order provided USBHPC receives the completed enrollment form with the court or administrative order attached and any required Plan Premium.

Except for Emergency and Urgently Needed Services, to receive coverage, all care must be provided or arranged in the USBHPC Service Area by a Participating Provider.

Late Enrollment

In addition to a special enrollment period due to the addition of a new legal Spouse, Domestic Partner or child, there are certain circumstances when Eligible Employees and their eligible Family Members may enroll outside of the University's open enrollment period. These circumstances include:

- The eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) declined in writing to enroll in USBHPC when they were first eligible because they had other health coverage; and
- USBHPC cannot produce a written statement from the University or eligible employee stating that prior to declining coverage, the eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) was provided with, and a signed acknowledgment of, an explicit written notice in boldface type specifying that failure to elect coverage with USBHPC during the initial enrollment period permits USBHPC to impose, beginning on the date the Eligible Employee (on his or her behalf, or on behalf of any eligible Dependents) elects coverage under the Behavioral Health Plan, an exclusion of coverage under the Behavioral Health Plan for a period of 12 months from the date of election of coverage under the Behavioral Health Plan, unless the eligible employee or Family Member can demonstrate that he or she meets the requirements for late enrollment.

- The other Behavioral Health Services are no longer available due to:
 - The employee or eligible Family Member exhausting COBRA or Cal-COBRA continuation coverage under another plan;
 - The termination of employment or reduction in work hours of a person through whom the Eligible Employee or eligible Family Member was covered; or
 - The termination of the other plan coverage; or
 - The cessation of an employer's contribution toward the employee or eligible Family Member coverage; or
 - The death, divorce or legal separation of a person through whom the employee or eligible Family Member was covered.
 - The loss of coverage under the Healthy Families Program due to exceeding the program's income or age limits, or loss of no-share-of-cost Medi-Cal coverage; or loss of coverage through the Covered California, California's Health Benefit Exchange; or
 - The employee or eligible Family Member incurs a claim that would exceed a lifetime limit on all benefits; or
 - The employee or eligible Family Member previously declined coverage under the Behavioral Health Plan, but the employee or eligible Family Member becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP) or the AIM Program. Coverage will begin only if we receive the completed enrollment application and any required Behavioral Health Plan Premiums within 60 days of the date of the determination of the subsidy eligibility; or
 - The employee or eligible Family Member loses eligibility under Medicare or Children's Health Insurance Program (CHIP), the AIM Program, or the Medi-Cal program; or Covered California, California's Health Benefit Exchange. Coverage will begin only if we receive the completed enrollment application and any required Health Plan Premiums within 60 days of the date coverage ended.
- The Court has ordered behavioral health coverage to be provided for your Spouse or minor child.
 - Open Enrollment Period – You may enroll during the Open Enrollment period from November 1 of the preceding calendar year through January 31 of the benefit year, inclusive.
 - Special Open Enrollment Period – You may enroll within 60 days if one of the following events happens to one of your family Members:
 - The person loses Minimum Essential Coverage for a reason other than nonpayment of premium or rescission of coverage.
 - The person gains a Dependent or becomes a Dependent.
 - The person's enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous due to the plan's error, misrepresentation, or inaction.
 - The health coverage issuer violated a material provision of the health care coverage contract.

- The person becomes eligible for membership due to a permanent move.
- The person is mandated to be covered as a Dependent according to a valid state or federal court order.
- The person has been released from incarceration.
- The person was receiving services from a contracting Provider under another health benefit plan for one of the conditions described in the Continuity of Care Conditions as defined in Section 10. Definitions and that Provider is no longer a participating provider in the health benefit plan.
- The person is a Member of the reserve forces of the United States military returning from active duty or a Member of the California National Guard returning from active duty services.

If the Eligible Employee or an eligible Family Member meets these conditions, the Eligible Employee must request enrollment with USBHPC following the termination of the other Behavioral Health Plan coverage as shown above. USBHPC may require proof of loss of the other coverage. Enrollment will be effective on the first of the following month if premium is received from the 1st to the 15th of the month. Enrollment will be effective on the first of the second succeeding month for premiums received on the 15th to the end of the month. Notwithstanding the above, coverage shall be effective on the date of birth, adoption, or placement of adoption for a new Dependent child due to birth, adoption or placement for adoption. Coverage shall be effective on the first day of the month following the date USBHPC receives the request for special enrollment in the case of a new legal spouse, Domestic Partner or loss of Minimum Essential Coverage.

Updating Your Enrollment Information

Please notify the University and USBHPC of any changes to the information you provided on the enrollment application within 31 days of the change. This includes changes to your name, address, telephone number, marital status or the status of any enrolled Family Members. For reporting changes in marital and/or Dependent status, please see Adding Family Members to Your Coverage.

Ending Coverage

Usually, your enrollment in USBHPC terminates when the Subscriber or enrolled Family Member is no longer eligible for coverage under the University's health plan. The University determines the date in which coverage will terminate. Coverage can be terminated, however, because of other circumstances as well, which are described below.

Continuing coverage under this Plan is subject to the terms and conditions of the University's Group Agreement with USBHPC.

When the Group Agreement between the University and USBHPC is terminated, all members covered under the Group Agreement become ineligible for coverage on the date of termination. If the Group Agreement is terminated by USBHPC for nonpayment of Premiums, coverage for all members covered under the Group Agreement will be terminated at the end of the 30-day grace period. The grace period shall begin no sooner than the first day following the last day of paid coverage. USBHPC will continue to provide coverage during the grace period.

According to the terms of the Group Agreement, the University is responsible for notifying you of termination by providing copy of the Notice of End of Coverage, or Notice of Cancellation, Rescission or Termination it receives from USBHPC.

Termination of Benefits

Termination of Group Agreement

USBHPC has the right to terminate the Group Agreement between the University and USBHPC in the following situations:

- **For Nonpayment of Premiums.** The Group Agreement may be terminated if the University did not pay required Premiums when due. USBHPC will mail the University a Notice of Start of Grace Period no later than five (5) days after the last day of paid coverage. If the University fails to remit premium by the end of the Grace Period, USBHPC will mail a Notice of End of Coverage to the University no later than five (5) calendar days after the date coverage ended. The University will provide copy of the Notice of Start of Grace Period and the Notice End of Coverage to Enrollees following its receipt from USBHPC as set forth in the Group Subscriber Agreement.

- **Termination for Reasons Other than Non-Payment of Premium.** If USBHPC terminates or cancels the Group Agreement for reasons other than Non-Payment of Premium, USBHPC shall send a Notice of Cancellation, Rescission, or Nonrenewal to the University at least 30 days before the cancellation, rescission or nonrenewal, or time period otherwise noted in the descriptions below based on the reason for termination. A Notice of End of Coverage shall be sent following the date of termination. Reasons for termination other than non-payment of premium may include:
 - USBHPC confirms the University demonstrates fraud or an intentional misrepresentation of material fact under the terms of the health care service plan contract.
 - USBHPC confirms the University violates a material contract provision relating to employer contribution or group participation rates.
 - USBHPC ceases to provide or arrange for the provision of health benefits for new health care service plan contracts in the individual or group market, or all markets, in California, when the following conditions are satisfied:
 - USBHPC provides notice of its decision to cease new or existing health benefit plans in California to the Director of the Department of Managed Health Care, and the University, and the enrollees covered under those contracts at least 180 days prior to the discontinuation of those contracts
 - USBHPC shall not cancel the Plan for 180 days after the date of the notice described above and, shall continue to be governed by California rules and requirements during this period.
 - If USBHPC ceases to write new health benefit plans in the individual or group market, or all markets, in California, it shall be prohibited from offering for sale health benefit plans in that market or markets in California for a period of five (5) years from the date of the discontinuation.
 - USBHPC withdraws a health benefit plan in the individual or group market, when all of the following conditions are satisfied:
 - USBHPC notifies all affected employer groups and enrollees and the Director of the Department of Managed Health Care at least 90 days prior to the discontinuation of the Plan.
 - USBHPC makes available to the University all health benefit plans that it makes available to new group business.
 - In exercising the option to discontinue a health benefit plan under this paragraph and in offering the option of coverage under the above section, USBHPC acts uniformly without regard to the claims experience of the University or any health status-related factor relating to enrollees or potential enrollees.

- USBHPC terminates coverage, in the case of a group health benefit plan, if the University ceases to be a member of a guaranteed association. Such termination will be made uniformly without regard to any health status-related factor relating to any enrollee.

Grievance Right. An enrollee, subscriber, or employer group (or their legal representative) has the right to submit a grievance if they believe the Group Agreement, or their enrollment or subscription has been or will be improperly terminated, cancelled, rescinded or not renewed. The grievance will be handled as an expedited grievance. A grievance may also be made electronically, verbally or in writing to the Director of the Department of Managed Health Care.

A “grievance” as used in this section means a written or oral expression of dissatisfaction to USBHPC or the Director of the Department of Managed Health Care regarding USBHPC and/or provider, including a written or oral expression of dissatisfaction by an enrollee, subscriber or employer group who believes their Group Agreement, enrollment, or subscription has been or will be improperly terminated, cancelled, rescinded or not renewed.

If you believe the Group Agreement or your coverage has been or will be wrongly canceled, rescinded or not renewed, you may request a review by the Department of Managed Care (DMHC) Director.

Termination/Rescission of Enrollee for Fraud or Misrepresentation

An Enrollee’s coverage may be rescinded if USBHPC can demonstrate the enrollee performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the Group Agreement. “Rescission” is the cancellation of coverage for fraud or intentional misrepresentation of material fact that has a retroactive effect.

Under no circumstances will a Member be terminated due to health status or the need for Behavioral Health Services. Any Member who believes his or her enrollment has been terminated due to the Member’s health status or requirements for Behavioral Health Services may request a review of the termination by the DMHC. For more information contact the USBHPC Customer Service Department.

If USBHPC intends to terminate or rescind coverage as described above, USBHPC shall send notice to the enrollee via regular certified mail at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and notifying the enrollee of his or her right to appeal that decision to the director of the California Department of Managed Health Care.

USBHPC shall not terminate or rescind the plan contract for any reason after 24 months following issuance, and shall not cancel the contract, limit any of the provisions of the plan contract, or raise premiums on the plan contract due to any omissions, misrepresentations, or inaccuracies in the enrollment form, whether willful or not.

Other Reasons for Termination of Coverage Related to Loss of Eligibility

In addition to terminating the Group Agreement, USBHPC may terminate a Member’s coverage for any of the following reasons related to loss of eligibility:

- The Member no longer meets the eligibility requirements established by the University.
- The Member no longer meets the eligibility requirements under the Health Plan because the Member establishes his or her Primary Residence outside the USBHPC Service Area and does not work inside the USBHPC Service Area (except for a Dependent Child, or a child subject to a qualified child medical support order, for more information refer to Qualified Medical Child Support Order in this section).

Under no circumstances will a Member be terminated due to health status or the need for health care services. If a Member is Totally Disabled when the group’s coverage ends, coverage for the Totally Disabling

condition may be extended (please refer below to Total Disability). Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care. For more information, call our Customer Service department.

Note: If a Group Subscriber Agreement is terminated by USBHPC, reinstatement with USBHPC is subject to all terms and conditions of the Group Subscriber Agreement between USBHPC and the University.

Ending Coverage – Special Circumstances for Enrolled Family Members

Enrolled Family Members terminate on the same date of termination as the Subscriber. If there is a divorce, the Spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered. Dependent children lose their eligibility if they reach the Limiting Age established by the employer and do not qualify for extended coverage as a disabled Dependent or student Dependent (see paragraph above entitled, Continuing Coverage for Students and Certain Disabled Dependents).

Total Disability

If you or your enrolled Dependent(s) is Totally Disabled as a result of a behavioral health condition at the time your University's Agreement with USBHPC is terminated and you or your enrolled Dependent(s) continue to be Totally Disabled, USBHPC will continue to provide coverage to the Totally Disabled Member for the behavioral health condition causing the Total Disability for up to twelve (12) months or until the Member is covered under another Health Plan which does not have an enforceable preexisting condition clause.

To qualify for these benefits, you must provide written proof of the behavioral health disability acceptable to USBHPC within ninety (90) days of the date on which coverage for the University was terminated. Also see the definition of "Totally Disabled or Total Disability" in the definitions section of this *Combined Evidence of Coverage and Disclosure Form*. USBHPC may require you to periodically submit additional information to verify your behavioral health Total Disability.

Coverage Options Following Termination

If your coverage through this Combined Evidence of Coverage and Disclosure Form ends, you and your enrolled Family Members may be eligible for additional continuation coverage.

Federal COBRA Continuation Coverage

If the Subscriber's employer group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you may be entitled to temporarily extend your coverage under the Plan at group rates, plus an administration fee, in certain instances where your coverage under the Plan would otherwise end. This discussion is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. However, your employer group is legally responsible for informing you of your specific rights under COBRA. Therefore, please consult with your employer group regarding the availability and duration of COBRA continuation coverage.

1401 Extended Continuation Coverage After COBRA

In the event your COBRA coverage began on or after January 1, 2003, and you have used all of your COBRA benefits as described above, you may be eligible to continue benefits under California Continuation Coverage at 110 percent of the Premium charged for similarly situated Eligible Employees currently working at your former employment. A notice will be provided to you by USBHPC at the time your COBRA benefits will run out, allowing up to 18 more months under California Continuation COBRA. However, your California Continuation COBRA benefits will not exceed a combined total of 36 months from the date COBRA coverage began.

Example: As a result of termination from your former employer (for reasons other than gross misconduct), you applied for and received 18 continuous months of group Health Plan benefits under your federal COBRA

benefits. California Continuation COBRA may extend your benefits another 18 consecutive months. Your combined total of benefits between COBRA and California Continuation COBRA is 36 months.

1401 Extended Continuation Coverage Enrollment and Premium Information After COBRA

You must notify USBHPC within 60 days from the date your COBRA coverage terminated or will terminate because of your qualifying event if you wish to elect this continuation coverage, or within 60 days from the date you received notice from USBHPC. If you fail to notify USBHPC within 60 days of the date of your qualifying event, you will lose your rights to elect and enroll on California Continuation Coverage after COBRA. The 60-day period will be counted from the event which happened last. Your request must be in writing and delivered to USBHPC by first-class mail, or other reliable means of delivery, including personal delivery, express mail or private courier company. Upon receipt of your written request, an enrollment package to elect coverage will be mailed to you by USBHPC. You must pay your initial Premiums to USBHPC within 45 days from the date USBHPC mails your enrollment package after you notified USBHPC of your intent to enroll. Your first Premium must equal the full amount billed by USBHPC. Your failure to submit the correct Premium amount billed to you within the 45-day period, which includes checks returned to USBHPC by your financial institution for non-sufficient funds (NSF), will disqualify you from this available coverage and you will not be allowed to enroll.

Termination of 1401 Extended Continuation Coverage After COBRA

Your coverage under California Continuation Coverage will terminate when:

1. You have received 36 months of continuation coverage after your qualifying event date; or
2. If you cease or fail to make timely Premiums; or
3. Your former employer or any successor employer ceases to provide any group benefit plan to his or her Eligible Employees; or
4. You no longer meet eligibility for USBHPC coverage, such as moving outside the USBHPC Service Area; or
5. The contract for health care services between your employer and USBHPC is terminated; or
6. You become entitled for Medicare. **Note:** If you were eligible for the 29-month extension due to disability and you are later determined by the Social Security Administration to no longer be disabled, your benefits will terminate the later of 36 months after your qualifying event or the first of the month following 31 days from date of the final Social Security Administration determination, but only if you send the Social Security Administration notice to USBHPC within 30 days of the determination.
7. If you were covered under a prior carrier and your former employer replaces your prior coverage with USBHPC coverage, you may continue the remaining balance of your unused coverage with USBHPC, but only if you enroll with and pay Premiums to USBHPC within 30 days of receiving notice of your termination from the prior group Health Plan.

If the contract between your former employer and USBHPC terminates prior to the date your continuation coverage would terminate under California Continuation COBRA, you may elect continuation coverage under your former employer's new benefit plan for the remainder of the time period you would have been covered under the prior group benefit plan.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Continuation coverage under this Plan may be available to you through your employer under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). The continuation coverage is equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Behavioral Health Plan. These benefits may be available to you if you are absent from

employment by reason of service in the United States' uniformed services, up to the maximum 24-month period if you meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through COBRA or Cal-COBRA. Your employer will provide written notice to you for USERRA continuation coverage.

If you are called to active military duty and are stationed outside of the Service Area, you or your eligible Dependents must still maintain a permanent address inside the Service Area and must choose a Participating Provider within 30 miles of that address. To obtain coverage, all care must be provided or arranged in the Service Area, except for Emergency Services and Urgently Needed Services.

The Premium for USERRA Continuation of benefits is the same as the Premium for other USBHPC Members enrolled through your employer plus a two percent additional surcharge or administrative fee, not to exceed 102 percent of your employer's active group Premium. Your employer is responsible for billing and collecting Premiums from you or your Dependents and will forward your Premiums to USBHPC along with your employer's Premiums otherwise due under this Agreement. Additionally, your employer is responsible for maintaining accurate records regarding USERRA continuation Member Health Plan Premium, qualifying events, terminating events and any other information that may be necessary for USBHPC to administer this continuation benefit.

California Military Families Financial Relief Act

Members of the United States Military Reserve and National Guard who terminate coverage as a result of being ordered to active duty on or after January 1, 2007, may have their coverage reinstated without waiting periods or exclusion of coverage for Pre-Existing Conditions. Please call Member Services for information on how to apply for reinstatement of coverage following active duty as a reservist.

Behavioral Health Benefits

(Note: Words in **bold** print are either references to sections within this Evidence of Coverage (EOC) or defined in the Glossary at the end of this EOC.)

What USBHPC Covers

Behavioral health benefits are payable for **Covered Expenses** incurred by a **Member** for **Behavioral Health Services** received from **Participating Providers**.

The best way to ensure services will be covered is to call USBHPC at (888) 440-UCAL (8225) in advance for preauthorization. Calling USBHPC will assure referral to the most appropriate treatment.

There are certain **Non-Routine Outpatient** services that require preauthorization; see the section below titled **Preauthorization Requirement and Utilization Review**. Further, preauthorization is required for inpatient services; see section below titled **Preauthorization Requirement and Utilization Review**.

In all other cases, treatment will be covered as long as it is **Medically Necessary**

For further information, see the section titled **Preauthorization Requirements and Utilization Review**.

Each **Member** must satisfy the copayment requirements before any payment is made for certain covered **Behavioral Health Services**. The behavioral health benefit will then pay the **Covered Expenses** as shown in **Schedule of Benefits**.

A **Covered Expense** is incurred on the date the **Behavioral Health Service** is provided. The **Covered Expense** is the actual cost to the **Member** of the **Reasonable Charge** for **Behavioral Health Services**

provided. The Company 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 (CPT) and/or Diagnostic and Statistical Manual of Mental Disorders (DSM) Code, except as listed in the **What's not Covered – Exclusions** section
- As reported by generally recognized professionals or publications.
- As required by law.

Behavioral Health Services are services and supplies which are:

- **Covered Services, for Mental Health and Substance Abuse Treatment**
- Given while the **Member** is covered under this **Plan**.
- Rendered by one of the following providers - except that, where medically necessary, for the treatment of Severe Mental Illness or Serious Emotional Disturbance of a Child, services may be provided by other providers of care subject to applicable law:
 - **Physician**
 - **Psychologist**
 - **Licensed Counselor**
 - **Hospital/Facility**
 - **Treatment Center**
 - **Social Worker**
 - **Qualified Autism Service Provider, Qualified Autism Service Professional, Qualified Autism Service Paraprofessional**
 - **Registered Mental Health Psychiatric Nurse**
 - **Advanced Practice Registered Nurse**

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

- Assessment
- Diagnosis
- Medication Management
- Individual, family and group psychotherapy and other psychotherapeutic methods
- Psychological testing.
- Inpatient services, including **Hospital/Facility**-based treatment such as Acute Inpatient, Detoxification services, Residential Treatment, or Recovery Home treatment and any related inpatient Professional Services.
- Outpatient services, including treatment planning, biofeedback, intensive outpatient services, partial hospitalization/day treatment services, and methadone maintenance.
- “Behavioral health treatment” for pervasive developmental disorders and autism pursuant to a treatment plan prescribed by a **qualified autism service provider** and is administered by one of the following:
 - a **qualified autism service provider**;
 - a **qualified autism service professional** supervised by the **qualified autism service provider**, or;

- a **qualified autism service paraprofessional** supervised by a **qualified autism service provider** or **qualified autism service professional**.

The treatment plan shall have measurable goals over a specific timeline that is developed and approved by the **qualified autism service provider** for the specific patient being treated. The treatment plan shall be reviewed no less than once every six (6) months by the **qualified autism service provider** and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the **qualified autism service provider** does all of the following:

- Describes the patient’s behavioral health impairments or developmental challenges that are to be treated.
- Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan’s goal and objectives, and the frequency at which the patient’s progress is evaluated and reported.
- Provides intervention plan that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
- Discontinues intensive behavioral invention services when the treatment goals and objectives are achieved or no longer applicable.

The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the Plan upon request.

“Behavioral health treatment” means professional services and treatment programs, including applied behavioral analysis and evidence- based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet the criteria described above.

- **Telehealth.** No face-to-face contact is required between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the **Plan**. A definition is provided in the **Glossary**. (This is not the same as **Telephonic Counseling** which is not covered under this plan, except to the extent permitted by law.)

Services and supplies will not automatically be considered **Covered Services** because they were prescribed by a **Provider**.

Preauthorization Requirements and Utilization Review

The following requirements apply in cases other than when **Emergency Services and Care** is needed; please see the section below for further information about **Emergency Services and Care**. USBHPC can be contacted 24 hours a day, 7 days a week at 1-888-440-UCAL (8225) for preauthorization of **Covered Services** as required under this benefit plan. **Detailed information about preauthorizations and benefit determinations are provided in the section of this EOC entitled, “Benefit Determinations”.**

Preauthorization of **Inpatient Treatment** is required. **Inpatient Treatment** includes **Hospital/Facility-** based treatment such as Acute Inpatient, Detoxification services, Residential treatment, or Recovery Home treatment.

Preauthorization of **Non-Routine Outpatient Treatment** is required. These services include, but are not limited to, psychological testing, outpatient ECT (electro-convulsive therapy), biofeedback, treatment planning, **Behavioral Health Treatment** services for pervasive developmental disorders or autism, Structured/Intensive Outpatient Program treatment, Partial Hospitalization/Day Treatment and **methadone maintenance**.

If a **Member** does not contact USBHPC for an authorization for treatment before **Behavioral Health Services** are provided as required, benefits under this **Plan** may not be covered

Non-Urgent Services: When preauthorization is required for non-urgent services, the initial authorization determination is made as soon as possible to accommodate the clinical condition of the Member but not to exceed five (5) business days of receipt of the request. If the request is made by a provider or facility, the requesting provider or facility is notified of the authorization decision by telephone or facsimile within twenty-four (24) hours of the decision. Written notice of decisions resulting in denial, delay, or modification of the request for non-urgent care is sent to the **Member** and provider/facility, within two (2) business days of the decision.

Urgent Services: When preauthorization is required for urgent services, the initial authorization determination is made as soon as possible to accommodate the clinical condition but not to exceed seventy-two (72) hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. The treating provider and facility are notified verbally of the authorization decision within twenty-four (24) hours of the decision. Written notice of decisions resulting in denial, delay, or modification of the request for urgent services is transmitted to the **Member** and provider/facility within two (2) business days of the decision, not to exceed seventy-two (72) hours from the time of the request.

Detailed information about pre-authorizations and benefit determinations are provided in the section of this EOC entitled, "Benefit Determinations".

Notice of Right to Additional Information

If you would like a copy of USBHPC's description of processes utilized for the authorization or denial of Behavioral Health Services, or the criteria or guidelines related to a particular condition, you may contact USBHPC Customer Service Department or visit the USBHPC web site at www.liveandworkwell.com.

Emergency Services and Care

Emergency Services and Care do not require prior authorization.

When **Emergency Services and Care** is required for Mental Health and Substance Abuse Treatment, the **Member** (or his/her representative or his/her **Provider**) must call Optum within forty-eight (48) hours after the **Emergency Services and Care** is given. If it is not reasonably possible to make this call within forty-eight (48) hours, the call must be made as soon as reasonably possible. USBHPC will pay for **Emergency Services and Care** services regardless of the **Provider's** contract status.

Payment for emergency services and care may be denied only if USBHPC reasonably determines that the emergency services and care were never performed. USBHPC may also deny reimbursement to a provider for a medical screening examination in cases when the Member did not require emergency services and care and the Member reasonably should have known that an emergency did not exist.

When the **Emergency Services and Care** has ended, the **Member** (or his or her representative or his/her **Provider**) must contact USBHPC to get authorization for post-stabilization services. USBHPC will make initial authorization for such services within one-half (1/2) hour of receipt of the request. If the **Member** does not get prior authorization as required, any additional services may not be covered. A request for post-stabilization care is deemed authorized if a decision to authorize or not cover care is not reached by USBHPC within one-half (1/2) hour of receipt of the request.

If there is disagreement between the Plan and the provider regarding the need for post-stabilization services, USBHPC shall assume responsibility for the care of the Member either by having a Participating Provider personally take over their care within a reasonable amount of time after the disagreement, or by having another Participating general acute care hospital agree to accept the transfer of the patient. This requirement does not apply to necessary care provided in a Hospital outside of the service area of USBHPC. If USBHPC fails to meet these requirements, further necessary care shall be deemed to have been authorized by USBHPC. Payment for this care will not be denied.

The **Plan** will pay for all **Covered Services** rendered to a **Member** prior to stabilization of the **Member's Emergency Services and Care**, or during periods of destabilization when the **Member** needs immediate **Emergency Services and Care**. **Members** should use the "911" emergency response system (where established) appropriately when an emergency medical condition exists that requires an emergency response.

Copayments

Before behavioral health benefits are payable, each Member must satisfy **Copayment** requirements as shown in the **Schedule of Benefits**.

Copayment is the amount of **Covered Expenses** the **Member** must pay to a **Provider** at the time services are given.

Out-of-Pocket Feature

As shown in the **Schedule of Benefits**, certain **Covered Expenses** are subject to the applicable Copayments until the Out-of-Pocket Maximum has been reached during a **Calendar Year**. Once the member's combined expenses for mental health, substance abuse, and medical services meet the Out-of-Pocket maximum, the member will have no further Out-of-Pocket expenses for covered mental health, substance abuse, or medical expenses for the rest of that **Calendar Year**. The annual Out-of-Pocket maximums for benefits can be met with covered mental health, substance abuse, and medical expenses.

Individual Out-of-Pocket Maximum

For individual coverage, when the **Individual Out-of-Pocket Maximum** is reached in a **Calendar Year**, **Covered Expenses** are payable at 100% for that same person for the remainder of that year.

Family Out-of-Pocket Maximum

When the **Family Out-of-Pocket Maximum** is reached for a Member and the **Member's Family Members** combined in a Calendar Year, all **Covered Expenses** for Mental Health and Substance Abuse are payable at 100% of the rest of that year.

What's Not Covered - Exclusions

The following exclusions apply even if the services, supplies, or treatment described in this section are recommended or prescribed by the **Member's Provider** and/or are the only available service, supply or treatment options for the **Member's** condition. The exclusions or limitations described below shall not apply to any services, supplies or treatment that are medically necessary to treat a Severe Mental Illness or Serious Emotional Disturbance of a Child if those services are medically necessary.

This **Plan** does not cover services, supplies or treatment relating to, arising out of, or given in connection with the following. These exclusions and limitations do not apply to Medically Necessary services to treat severe mental illness (SMI) or serious emotional disturbances of a child (SED).

- Gambling Disorder, Neurological Disorders and other conditions with physical basis (e.g. Dementia), Impulse Control Disorder, Sleep Wake Disorder, and any "Unspecified Forms" of Disorders.
- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), except as otherwise required or provided for by law.
- Treatment or services that are medical in nature and covered under a medical plan.
- Outpatient prescription drugs or over-the-counter drugs and treatments. Outpatient prescription drugs prescribed by your provider may be covered under your prescription drug benefit.
- Services or supplies for Mental Health and Substance Abuse Treatment that are any of the following:
 - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
 - not consistent with prevailing national standards of clinical practice for the treatment of such

- conditions;
- not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;
- typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or
- not consistent with USBHPC's Clinical Criteria or best practices as modified from time to time. USBHPC may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.

This exclusion shall not be used to exclude coverage of behavioral health treatments for pervasive developmental disorder or autism as mandated by law. See the description of covered behavioral health treatment for pervasive developmental disorder or autism in this EOC in the listing of covered Behavioral Health Services.

- For adults only, treatment or services, except for the initial diagnoses, for a primary diagnoses of Mental Retardation, Learning, Motor Skills, and Communication Disorders, Conduct Disorder, Dementia, Sexual and Paraphilia Disorders (other than Sexual Identity Disorder), and Personality Disorders, as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by USBHPC. This exclusion shall not be read or interpreted to exclude coverage for **Medically Necessary** treatment of pervasive developmental disorders or autism through behavioral health treatments.
- For children only, treatment or services, except for the initial diagnoses, for a primary diagnoses of Mental Retardation, Learning, Motor Skills, and Communication Disorders as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by USBHPC. This exclusion shall not be read or interpreted to exclude coverage for **Medically Necessary** treatment of pervasive developmental disorders or autism through behavioral health treatments. See the description of covered behavioral health treatment for pervasive developmental disorder or autism in this EOC in the listing of covered Behavioral Health Services.
- Unproven, Investigational or Experimental Services. These are services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a **Covered Service** if the service, treatment, or device is considered to be unproven, investigational, or experimental. In the event services are denied on the basis of this exclusion the **Member** has the right to appeal through the **Independent Medical Review** process as described herein.
- Custodial Care except for the acute stabilization of the **Member** and returning the **Member** back to his or her baseline levels of individual functioning except that this exclusion does not apply to **Medically Necessary** behavioral health treatment when prescribed for pervasive developmental disorders or autism. Custodial care does not include Acute Inpatient, Detoxification services, Residential Treatment, or Recovery Home treatment and related Inpatient Professional Services. Care is determined to be custodial when:
 - it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the **Member's** competent functioning in activities of daily living; or
 - it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the **Member** to function outside a structured environment. This applies to **Members** for whom there is little expectation of improvement in spite of any and all treatment attempts.
- Neuropsychological testing when used for the diagnosis of attention deficit disorder.
- Examinations or treatment, unless it otherwise qualifies as a **Behavioral Health Service**, when:

- required solely for purposes of career, education, sports or camp, travel, employment, insurance or adoption;
 - ordered by a court except as required by law;
 - conducted for purposes of medical research; or
 - required to obtain or maintain a license of any type.
- Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
 - Services or treatment rendered by unlicensed **Providers**, except as may be authorized, permitted, or required by applicable law, including pastoral counselors, or which are outside the scope of the **Providers'** licensure. This exclusion does not apply to behavioral health treatment for pervasive developmental disorder or autism.
 - Personal convenience or comfort items including, but not limited to such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
 - Light boxes and other equipment including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
 - Private duty nursing services while confined in a facility.
 - Surgical procedures including but not limited to sex transformation operations.
 - Smoking cessation related services and supplies.
 - Travel or transportation expenses unless USBHPC has authorized the expenses in advance (or retrospectively in an emergency) for a **Member** to be transferred by ambulance to a mental health or substance abuse facility.
 - Services performed by a **Provider** who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the **Provider** may perform on himself or herself.
 - Services performed by a **Provider** with the same legal residence as the **Member**.
 - **Behavioral Health Services** for which the **Member** has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the **Plan**.
 - Charges in excess of any specified **Plan** limitations.
 - Any charges for missed appointments.
 - Any charges for record processing except as required by law.
 - Treatment or services received prior to **Member** being eligible for coverage under the **Plan** or after the date the **Members** coverage under the **Plan** ends.
 - **Telephonic counseling**, therapy performed over the telephone with a **Member** by a mental health or substance abuse professional, except to the extent permitted by law.

Participating Provider Charges Not Covered

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

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

A **Member** may reach an agreement with the **Participating Provider** to pay for services and supplies which are not **Covered Services** and therefore are not covered by this **Plan**. In this case, the **Participating Provider** may ask the **Member** to sign a patient financial responsibility form agreeing to pay for the services that are not **Covered Services**. However, these charges are not **Covered Expenses** under this **Plan** and are not payable by the Plan.

Claims Information

How to File a Claim

A **Participating Provider** will submit claims on behalf of the **Member**. All payments for Participating Services will be paid directly to the **Participating Provider**. See the section below entitled, "When Claims Must Be Filed".

In the event a **Member** incurs expenses for services or supplies while outside the United States, following are instructions as to how to submit the claim for reimbursement of **Covered Expenses**.

Claims are paid according to billed charges at the benefit level stated in the Schedule of Benefits 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/Retiree's name, Social Security Number, address and phone number.
- The patient's name.
- The Plan number (11280).
- The name, address and phone number of the Provider.
- The license level (for example, MD, PhD, LCSW, MFT, LPC, etc.) 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:

Optum Claims
P. O. Box 30760
Salt Lake City, UT
84130-0760

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

When Claims Must be Filed

You should not get a bill from a USBHPC Participating Provider because USBHPC's Participating Providers have been instructed to send all their bills to USBHPC for payment. You could get a bill from an emergency room provider if you use Emergency care. If this happens, send USBHPC the original bill or claim as soon as possible and keep a copy for yourself. You are responsible only for the amount of your copayment, as described in the Schedule of Benefits in this Evidence of Coverage and Disclosure Form.

You can submit the bill online (www.liveandworkwell.com) or to the proper mailing address identified above within 180 days of the date services or supplies for which the claim is made are received. Services received and charges for the services must be itemized, and clearly and accurately described on the form. If it is not possible to submit the claim within that time frame, an extension of up to 12 months may be allowed. However, USBHPC is not liable for the payment of benefits under this agreement if claims are not filed within the required time period.

USBHPC 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 USBHPC as soon as was reasonably possible.

USBHPC 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 USBHPC. In that case the **Member** 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 claimant's 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.

How and When Claims Are Paid

USBHPC will make a benefit determination as set forth below. Benefits will be paid as soon as USBHPC receives satisfactory proof of loss, except in the following cases:

- If the covered Employee/Retiree has financial responsibility under a court order for a Dependent's medical care, USBHPC will make payments directly to the **Provider** of care.
- If USBHPC pays benefits directly to **Participating Providers**.
- If the covered Employee/Retiree requests in writing when completing the claim form that payments be made directly to a **Provider**.

These payments will satisfy USBHPC's obligation to the extent of the payment.

USBHPC will send an Explanation of Benefits (EOB) to the covered Employee/Retiree. The EOB will explain how USBHPC considered each of the charges submitted for payment. If any claims are denied or denied in part, the **Provider** and covered Employee/Retiree will receive a written explanation.

Any benefits continued for Dependents after a covered Employee/Retiree's death will be paid to one of the following:

- The surviving spouse.
- A Dependent child who is not a minor, if there is no surviving spouse.

- A **Provider** of care who makes charges to the covered Employee/Retiree's Dependents for **Behavioral Health Services**.
- The legal guardian of the covered Employee/Retiree's Dependent.

Benefit Determinations

Pre-Service Claims

Pre-service claims are claims that require authorization or approval prior to receiving **Mental Health and Substance Abuse Services**. If the **Members** claim was a pre-service claim, and was submitted properly with all needed information, USBHPC will make its determination within five (5) business days of receipt of the request. Written notice of the decision will be provided to the **Member** and clinician or facility making the request on behalf of the Member within two (2) business days of the determination.

If additional information is needed to process the pre-service claim, or if USBHPC requires consultation by an expert reviewer, or if USBHPC needs an additional examination or test be performed upon the Member, USBHPC will notify the Member and provider that a decision cannot be made within the required time frame. The notification will specify the information requested or the additional examinations or tests required, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. The notification will be provided within five (5) business days of the request. The provider or Member has 45 days to provide the information.

The five (5) business day clock is suspended during the 45-day request period. If all of the information is received within the 45 day time frame, the five (5) business day clock starts up again and USBHPC will notify the Member within two (2) business days of the determination.

If the Member does not provide the needed information within the 45-day period to make a determination, the claim may be denied; USBHPC will make its determination based on available information. Any notice of denial or modification will explain the reason for denial or modification, refer to the part of the plan on which the denial or modification is based, and provide the claim appeal procedures.

Concurrent Care Claims

Concurrent Care Claims are claims filed for payment while **Mental Health and Substance Abuse Services** are underway.

If an ongoing **Course of Treatment** for inpatient and residential levels of care was previously approved for a specific period of time, the request will be decided upon and facility / clinician verbally notified within 24 hours from receipt of the request. The request must be made to USBHPC at least 24 hours prior to the end of the approved treatment. 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 ongoing outpatient, intensive outpatient, partial / day treatment levels of care for a specific period of time or number of treatments, and the **Member'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 **Member's** post-service claim is approved or denied, delayed or modified, he or she will receive a written notice from USBHPC within thirty (30) calendar days of receipt of the claim, as long as all needed information was provided with the claim. USBHPC will notify the Member within this 30-day period if additional information is needed to process the claim.

The Member has 45 days to provide any additional information. During the 45-day request period, USBHPC suspends the 30-calendar day clock. If the requested information is received within the 45-day time frame, the 30-calendar day clock starts up again once the information is received and USBHPC will approve, modify or deny the claim within the remainder of the 30 calendar days. If the Member does not provide the needed information within the 45-day period, his or her claim may be denied; USBHPC will make its determination based on available information.

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

Urgent Claims that Require Immediate Attention

Urgent Care claims are those claims that require authorization or a benefit determination for Mental Health and Substance Abuse Services when the Member's condition is such that the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the Member's life or health or could jeopardize the Member's ability to regain maximum function, or in the opinion of a physician with knowledge of the claimant's condition would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In these situations:

- When authorization is required, the initial decision is made as soon as possible to accommodate the Member's clinical condition but not to exceed seventy-two (72) hours of the request unless there is insufficient information provided to make a coverage determination. Verbal notification is made to the treating clinician and/or facility by telephone within twenty-four (24) hours of the decision. Written notice is provided to the Member and Provider within two (2) business days of the decision, not to exceed 72 hours from the time of the request.

If the Provider making the request or **Member** files an urgent claim improperly, USBHPC will notify the provider and **Member** 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, USBHPC will notify the provider and **Member** of the information needed within 24 hours after the claim was received. The provider and **Member** have 48 hours from written notice to provide the requested information.

The **Member and Provider** will be notified in writing of a benefit determination no later than two (2) business days after:

- USBHPC's decision following receipt of the requested information; USBHPC will make its decision no later than 72 hours of receipt of the requested information; or
- the end of the 48-hour period within which the **Provider or Member** was given to provide the additional information, if the information is not received within that time.

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

Notice of Right to Additional Information

If the Member and/or Provider would like a copy of USBHPC's description of processes utilized for the authorization or denial of Behavioral Health Services, or the criteria or guidelines related to a particular condition, the Member or Provider may contact USBHPC Customer Service Department or visit the USBHPC web site at www.liveandworkwell.com.

Questions or Concerns about Benefit Determinations

If the **Member** has a question or concern about a benefit determination, he or she may contact USBHPC’s customer service department. If the **Member** is not satisfied with a denial, delay or benefit modification he or she may appeal it as described below, “How to Appeal a Claim Decision”.

A **Member** has the right to appeal any determination of the plan which purports to rescind coverage under the policy/plan.

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

How to Appeal a Claim Decision

If the **Member** disagrees with a claim determination after following the above steps, he or she can contact USBHPC in writing, by facsimile, by telephone or online 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 **Member** believes the claim should be paid.
- Any documentation or other written information to support the request for claim payment.

The **Member’s** appeal request must be submitted to USBHPC within 180 days after he or she receives a claim denial, or notice that a claim has been modified or delayed.

An Appeal may be requested in writing, by facsimile, online, or by telephone:

Optum Appeals
 P.O. Box 30512
 Salt Lake City, UT
 84130-0512
www.liveandworkwell.com
 Fax: 1-855-312-1470
 Phone: 1-800-985-2410
 or 1-888-440-UCAL
 (8225)

See also the provision entitled, “Appealing a Behavioral Health Benefit Decision”.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed by USBHPC 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. USBHPC may consult with, or seek the participation of, medical experts as part of the appeal resolution process. The **Member** consents to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, the **Member** 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

Pre-service and Post-service Claim Appeals

The **Member** 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 appeal will be conducted and the **Member** will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim or claim that has been modified or delayed.

For appeals of **Post-Service Claims** as identified above, the appeal will be conducted and the **Member** will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim or claim that has been modified or delayed.

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

If the **Member** is not satisfied with the appeal decision, he or she has the right to request an **Independent Medical Review** as described below in the section entitled, **What to Do If You Have a Question about Independent Medical Review (IMR)**.

If any new or additional evidence is relied upon or generated by USBHPC during the determination of an appeal we will provide it to the **Member** free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

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

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 **Member's** health or the ability to regain maximum function. In these urgent situations:

The appeal does not need to be submitted in writing. The **Member** or his or her **Provider** should call USBHPC as soon as possible.

USBHPC will provide the **Member** with a written or electronic determination within three (3) calendar days following receipt of the request for review of the determination, taking into account the seriousness of the **Member's** condition. See the section below entitled, "Expedited Review Process".

Legal Actions

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

Incontestability of Coverage

The **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 the 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.

Information and Records

At times the Plan may need additional information from the **Member**. The **Member** must agree to furnish

USBHPC with all information and proofs that it may reasonably require regarding any matters pertaining to the Policy. If the **Member** does not provide this information when USBHPC requests it, USBHPC may delay or deny payment of benefits.

By accepting the **Mental Health and Substance Abuse Services** under the **Plan**, the **Member** authorizes and directs any person or institution that has provided services to him/her to furnish USBHPC with all information or copies of records relating to the services provided to the **Member**. USBHPC has the right to request this information at any reasonable time. This applies to all **Member's**, including Dependents whether or not they have signed the Employee enrollment form. USBHPC agrees that such information and records will be considered confidential.

USBHPC has the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the **Plan**, for appropriate medical review or quality assessment, or as USBHPC is required to do by law or regulation. During and after the term of the **Plan**, USBHPC and its related entities may use and transfer the information gathered under the **Plan** in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of a **Member's** medical records or billing statements, USBHPC recommends that USBHPC contact his/her **Provider**. **Providers** may charge reasonable fees to cover their costs for providing records or completing requested forms.

If USBHPC requests medical forms or records from USBHPC, USBHPC also may charge USBHPC reasonable fees to cover costs for completing the forms or providing the records.

In some cases, USBHPC will designate other persons or entities to request records or information from or related to the **Member**, and to release those records as necessary. USBHPC's designees have the same rights to this information as it has.

A statement describing USBHPC's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to a **Member** upon request.

Coordination of Benefits

Coordination of benefits applies when a **Member** 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 **Member**, 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.
- 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 a Retiree are determined before those of a plan which covers that person as a laid off employee or a Retiree. The same rule applies if a person is a dependent of a person covered as a Retiree 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 **Member** for the longer period are determined before those of the plan which covered that person for the shorter period.

Facility of Payment

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

Right of Recovery

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

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

Recovery Provisions

Refund of Overpayments

If USBHPC pays benefits for expenses incurred on account of a **Member**, that **Member** or any other person or organization that was paid must make a refund to USBHPC if:

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

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

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

Reimbursement of Benefits Paid

If USBHPC pays benefits for expenses incurred on account of a **Member**, the **Member** or any other person or organization that was paid must make a refund to USBHPC 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 USBHPC paid.

If the refund is due from another person or organization, the **Member** agrees to help USBHPC get the refund when requested.

If the **Member**, or any other person or organization that was paid, does not promptly refund the full amount, USBHPC may reduce the amount of any future benefits that are payable under this **Plan**.

USBHPC may also reduce future benefits under any other group benefits plan administered by USBHPC for the University. The reductions will equal the amount of the required refund. USBHPC may have other rights in addition to the right to reduce future benefits.

Subrogation

In the event a **Member** 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.

USBHPC will be subrogated and succeed to the **Member's** right of recovery against a third party. USBHPC may use this right to the extent of the benefits under this **Plan**.

The **Member** agrees to help USBHPC use this right when requested.

Effect of Government Plans

Government Plans (other than Medicare and Medicaid)

A government plan is any plan, program, or coverage other than **Medicare** or Medicaid, which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

If the **Member** is also covered under a Government Plan, this **Plan** does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that **Member** under the Government Plan.

This provision does not apply to any Government Plan which by law requires this **Plan** to pay primary.

Cancellation

Termination of Group Agreement

USBHPC has the right to terminate the UC (or, "Group Employer") group insurance agreement (the "group agreement") in the following situations:

- **For Nonpayment of Premiums.** The group agreement may be terminated if UC does not pay required Premiums when due. USBHPC will mail a Notice of Start of Grace Period to UC no later than five (5) days after the last day of paid coverage. If premium is not paid by the end of the Grace Period, USBHPC will mail a Notice of End of Coverage to UC no later than five (5) calendar days after the date coverage ended. In this situation, UC will provide copy of the Notice End of Coverage to Enrollees it received from USBHPC following its receipt.
- **Termination for Reasons Other than Non-Payment of Premium.** If USBHPC terminates or cancels the group agreement for reasons other than Non-Payment of Premium, USBHPC shall send a Notice of Cancellation, Rescission, or Nonrenewal to UC at least 30 days before the cancellation, rescission or nonrenewal. A Notice of End of Coverage shall be sent following the date of termination. Reasons for termination other than non-payment of premium may include:
 - For fraud or intentional misrepresentation of a material fact; or
 - For violation of material contract provision relating to employer contribution or group participation rates; or
 - For discontinuance of this health plan; or

- For discontinuance of all new and existing health plans.

The Notice of Cancellation, Rescission or Nonrenewal and the Notice of End of Coverage to Enrollees will be provided to enrollees by UC following receipt from USBHPC.

Termination of Member Benefits For Fraud or Intentional Misrepresentation of a Material Fact by Member. Your coverage may be rescinded if USBHPC can demonstrate you performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the Plan. Rescinding coverage means a cancellation of coverage for fraud or intentional misrepresentation of material fact that has a retroactive effect. (A cancellation of coverage with only a prospective effect is not “rescission”.) USBHPC will send Group Employer and you a written notice via regular certified mail at least 30 days prior to the effective date of rescission explaining the reasons for the intended rescission and information on the right and how to file a grievance of the decision to USBHPC and/or Director of the California Department of Managed Health Care. USBHPC shall not rescind coverage of a Member more than 24 months after the member’s effective date.

Grievance Right. A member, subscriber, or Group Employer (or their legal representative) has the right to submit a grievance if they believe the group agreement, or your enrollment or subscription has been or will be improperly terminated, cancelled, rescinded or not renewed. The grievance will be handled as an expedited grievance. A grievance may also be made electronically, verbally or in writing to the Director of the Department of Managed Health Care.

A “grievance” as used in this section means a written or oral expression of dissatisfaction to USBHPC or the Director of the Department of Managed Health Care regarding USBHPC and/or provider, including a written or oral expression of dissatisfaction by a member, subscriber or Employer Group who believes their group agreement, enrollment, or subscription has been or will be improperly terminated, cancelled, rescinded or not renewed.

If you believe the Group Agreement or your coverage has been or will be wrongly canceled, rescinded or not renewed, please refer to, “**Grievances Involving the Termination, Rescission, Cancellation or Non-Renewal of Benefits your Health Plan**”. in the Section below entitled, “**What to Do if You Have a Problem**” to learn how to request a review by the Department of Managed Care (DMHC) Director.

Under no circumstances will a Member be terminated due to health status or the need for health care services. If a Member is Totally Disabled when the group’s coverage ends, coverage for the Totally Disabling condition may be extended (please refer below to Total Disability). Any Member who believes his or her enrollment has been terminated due to the Member’s health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care. For more information, call our Customer Service department.

Note: If a Group Agreement is terminated by USBHPC, reinstatement with USBHPC is subject to all terms and conditions of the Group Agreement between USBHPC and the employer group.

What to Do if You Have a Problem

If you ever have a question or problem, contact the USBHPC Customer Service Department for resolution.

You may submit a grievance by contacting USBHPC by phone, by facsimile, by e-mail or online as follows:

U.S. Behavioral Health Plan, California
Attn: Grievances and Appeals
PO Box 30512

Salt Lake City, UT 84130-0512
Or
425 Market Street, 14th Floor
San Francisco, CA 94105

Fax: 1-855-312-1470
Phone: 888-440-UCAL (8225)
TDD line: 711

Or at the USBHPC Web Site: www.liveandworkwell.com

Language assistance services are available at no cost to you when filing a grievance with the Plan.

If you think you were discriminated against, you may file a grievance with the plan and, if not resolved, you can file a grievance with the Department of Managed Health Care (DMHC).

Upon receipt of a grievance the Plan will send a written acknowledgement within five (5) calendar days of receipt. The acknowledgment will advise the Member that the grievance has been received, the date of receipt, and provide the name of the Plan representative, telephone number and address of the Plan representative who may be contacted about the grievance.

If the Member's grievance requires an expedited review, the Member will receive a written statement on the disposition or pending status of the grievance no later than three (3) days from receipt. For all other complaints or grievances the Plan will resolve within thirty (30) days and notify the Member of the outcome.

You may submit a grievance with the Plan if you disagree with the "Notice of End of Coverage" or "Notice of Cancellation, Rescission or Nonrenewal" you may receive from your employer. The grievance request must be made at least 180 days from the date of the Notice. You may also take this complaint to California Department of Managed Health Care (DMHC) as noted in the section below, "Take your complaint to the California Department of Managed Health Care (DMHC)".

Take your complaint to the California Department of Managed Health Care (DMHC)

The DMHC oversees HMOs and other Health Plans in California and protects the rights of HMO Members. You can file a complaint with the DMHC if:

- You are not satisfied with USBHPC's decision about your complaint, or;
- You have not received the decision within thirty (30) days, or within three (3) days if the problem is urgent.
- You may file a complaint with DMHC if you disagree with the Notice of End of Coverage or Notice of Cancellation, Rescission or Nonrenewal you may receive from your employer within 180 days of the date of the Notice.

The DMHC may allow you to submit a complaint directly to the DMHC, even if you have not filed a complaint with USBHPC, if the DMHC determines that your problem requires immediate review.

For Help

Contact the DMHC Help Center at the toll-free telephone number **(1-888-466-2219)** to receive help with this process, or submit an inquiry in writing to the **DMHC Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725** or through the website: **<http://www.dmhc.ca.gov>**. The hearing and speech impaired may use the California Relay

Service's toll-free telephone number **1-800-735-2929 or 1-888-877-5378 (TTY)**.

Grievances Involving the Termination, Rescission, Cancellation or Non-Renewal of Benefits

If you believe that UC's Group Agreement with USBHPC, or your enrollment or subscription has been, or will be improperly terminated, rescinded, canceled or not renewed, you have the right to file a complaint with USBHPC. In addition to submitting complaint to USBHPC, you also have the right to submit a request to the Director of the Department of Managed Health Care (DMHC) to review your termination, cancellation, rescission, or non-renewal. You may submit a complaint to the DMHC even if you have not filed complaint with USBHPC first.

- You can file a complaint with USBHPC within at least 180 days from the date of a Notice of End of Coverage, or a Notice of Cancellation, Rescission or Non-Renewal by contacting the USBHPC customer service department at 1-888-440-8225 or by visiting USBHPC's website: www.liveandworkwell.com
- USBHPC must give you and DMHC with a written statement on the disposition or pending status of the complaint within three (3) calendar days of receipt of the complaint by USBHPC.
- You can file complaint with DMHC immediately without waiting for USBHPC's decision on your complaint.

Appealing a Behavioral Health Benefit Decision

The individual initiating the appeal may submit written comments, documents, records and any other information relating to the appeal regardless of whether this information was submitted or considered in the initial determination. The **Member** may obtain, upon request and free of charge, copies of all documents, records, and other information relevant to the **Member's** appeal. An individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person will review the appeal.

The USBHPC Medical Director (or designee) will review your appeal and make a determination within a reasonable period of time appropriate to the circumstances but not later than thirty (30) days after receipt of the appeal, except in the case of "expedited reviews" discussed below. For appeals involving the delay, denial or modifications of **Behavioral Health Services**, the written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying or modifying **Behavioral Health Services** based on a finding that the services are not **Covered Services**, the response will specify the provisions in the plan contract that exclude that coverage.

See also the section entitled, "How to Appeal a Claim Decision".

Expedited Review Process

Appeals involving an imminent or serious threat to the health of the **Member**, including, but not limited to, severe pain, potential loss of life, limb or other major bodily functions will be immediately referred to the USBHPC Medical Director for expedited review, regardless of whether such appeal is received orally or in writing.

If an appeal has been sent to the USBHPC Medical Director for immediate expedited review, USBHPC will immediately inform the **Member** of his or her right to notify the Department of Managed Health Care of the grievance and will provide the Covered Person with a written statement on the disposition or pending status of the grievance no later than three (3) calendar days from receipt of the appeal. The Department of Managed Health Care may waive the requirement that you complete the appeals process or participate in the appeals process if the Department of Managed Health Care determines that an earlier review is necessary.

Independent Medical Review of Grievances Involving a Disputed Behavioral Health Service

A **Member** may request an Independent Medical Review (IMR) of disputed **Behavioral Health Services** from the Department of Managed Health Care if the **Member** believes that **Behavioral Health Services** have been improperly denied, modified or delayed by USBHPC. A "disputed Behavioral Health Service" is any **Behavioral**

Health Service, requested by you or your provider, eligible for coverage that has been denied, modified or delayed, in whole or in part because the service is experimental or investigational or is not Medically Necessary. The IMR process is in addition to the procedures and remedies that are available to the **Member** under the Appeal Process described above. If the complaint or appeal pertains to a disputed **Behavioral Health Service** subject to IMR (as described below), the complaint or appeal should be filed within 180 days of receiving a denial notice.

Completed applications for IMR should be submitted to the Department of Managed Health Care. The **Member** pays no fee to apply for IMR. The **Member** has the right to include any additional information or evidence not previously provided to USBHPC in support of the request for IMR. USBHPC will provide the **Member** with an IMR application form with any grievance disposition letter that denies, modifies or delays Behavioral Health Services. The **Member** may also reach the Department of Managed Health Care at (1-888-466-2219) or TDD line (1-877-688-9891).

A decision not to participate in the IMR process may cause the **Member** to forfeit any statutory right to pursue legal action against USBHPC regarding the disputed behavioral health service.

IMR Eligibility for Independent Medical Review: Experimental or Investigational Treatment Decisions

If you suffer from a Life-Threatening or Seriously Debilitating condition, you may have the opportunity to seek IMR of the coverage decision regarding Experimental or Investigational therapies under California's Independent Medical Review System pursuant to Health and Safety Code Section 1370.4. Life-Threatening means either or both of the following: (a) conditions where the likelihood of death is high unless the course of the condition is interrupted; (b) conditions with potentially fatal outcomes, where the endpoint of clinical intervention is survival. Seriously Debilitating means conditions that cause major irreversible morbidity.

To be eligible for IMR of Experimental or Investigational treatment, your case must meet all of the following criteria:

1. Your Provider certifies that you have a Life-Threatening or Seriously Debilitating condition for which:
 - a. Standard therapies have not been effective in improving your condition, or
 - b. Standard therapies would not be medically appropriate for you, or
 - c. There is no more beneficial standard therapy covered than the proposed Experimental or Investigational therapy proposed by your Provider under the following paragraph.
2. Either (a) your Provider has recommended a treatment, drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, and he or she has included a statement of the evidence relied upon by the Provider in certifying his or her recommendation; or (b) you or your non-Participating Provider – who is a licensed, board certified or board-eligible Provider qualified to practice in the specialty appropriate to treating your condition – has requested a therapy that, based on two documents of medical and scientific evidence identified in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial than any available standard therapy. To satisfy this requirement, the Provider certification must include a statement detailing the evidence relied upon by the Provider in certifying his or her recommendation. (Please note that USBHPC is not responsible for the payment of services rendered by non-Participating Providers who are not otherwise covered under your benefits.)
3. A USBHPC Medical Director has denied your request for a treatment or therapy, drug, device or procedure recommended or requested pursuant to the above paragraph.
4. The treatment, drug, device, procedure or other therapy recommended pursuant to Paragraph 2 above would be a Covered Service, except for a determination that the treatment, drug, device, procedure or other therapy is Experimental or Investigational.

If you have a Life-Threatening or Seriously Debilitating condition and your request for Experimental or Investigational therapy is denied, USBHPC will send a written notice of the denial within two business days of the decision. The notice will advise you of your right to request IMR, and include a Provider certification form and an application form with a preaddressed envelope to be used to request IMR. (Please note that you may request an IMR,

if your request for Experimental or Investigational therapy is denied, without going through the USBHPC grievance process.)

Disputed Behavioral Health Services Regarding Medical Necessity

You may also request IMR when any Behavioral Health Service has been denied, modified or delayed by USBHPC or one of its Providers, in whole or in part, due to a finding that the service is not Medically Necessary. (Note: Disputed Behavioral Health Services do not encompass coverage decisions. Coverage decisions are decisions that approve or deny services substantially based on whether or not a particular service is included or excluded as a covered benefit under the terms and conditions of your coverage.)

You are eligible to submit an application to the Department of Managed Health Care for IMR of a Disputed Behavioral Health Service if you meet all of the following criteria:

- The **Member's** Provider has recommended a Behavioral Health Service as Medically Necessary; or
- The **Member** has received Urgently Needed Services or Emergency Services that a Provider determined was Medically Necessary; or
- The **Member** has been seen by a Participating Provider for diagnosis or treatment of the medical condition for which the **Member** sought independent review;
- The disputed Behavioral Health Service has been denied, modified or delayed, based in whole or in part on a decision that the Behavioral Health Service is not Medically Necessary; and
- The **Member** has filed a grievance with USBHPC and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If the grievance requires expedited review, the **Member** may bring it immediately to the Department of Managed Health Care's attention. They may waive the preceding requirement that the **Member** follow USBHPC's grievance process in extraordinary and compelling cases.

Accepted Applications for the Independent Medical Review

Upon receiving a **Member's** application for IMR, the Department of Managed Health Care will review the request and notify the **Member** whether the **Member's** case has been accepted. If the **Member's** case is eligible for IMR, the dispute will be submitted to an independent medical review organization (IRO) contracted with the Department of Managed Health Care for review by one or more expert reviewers, independent of USBHPC, who will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of behavioral health professionals knowledgeable in the treatment of the **Member's** conditions, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither the **Member** nor USBHPC will control the choice of expert reviews.

USBHPC must provide the following documents to the IRO within three business days of receiving notice from the Department of Managed Health Care that the **Member** has successfully applied for an IMR:

- The relevant medical records in the possession of USBHPC or its Participating Providers;
- All information provided to the **Member** by USBHPC and any of its Participating Providers concerning USBHPC and Participating Provider decision regarding the **Member's** condition and care (including a copy of USBHPC's denial notice sent to the **Member**).
- Any materials that the **Member** or Provider submitted to USBHPC and its Participating Providers in support of the request for the Behavioral Health Services.
- Any other relevant documents or information used by USBHPC or its Participating Providers in determining whether the Behavioral Health Services should have been provided and any statement by USBHPC or its Participating Providers explaining the reason for the decision. USBHPC will provide copies of these documents

to the **Member** and the **Member's** Provider unless any information in them is found by the Department of Managed Health Care to be privileged.

If there is an imminent and serious threat to the **Member's** health, USBHPC will deliver the necessary information and documents listed above to the IRO within 24 hours of approval of the request for IMR.

If there is any information or evidence the **Member** or the **Member's** Provider wish to submit to the Department of Managed Health Care in support of IMR that was not previously provided to USBHPC, the **Member** may include this information with the IMR application. Also as required, USBHPC or the **Member's** Provider must provide to the Department of Managed Health Care or the IRO copies of any subsequent relevant behavioral health records, and any newly developed or discovered relevant records after the initial documents are provided, and respond to any requests for additional records or other relevant information from the expert reviewers.

The Independent Medical Review Decision

The independent review panel will render its analysis and recommendations on the **Member's** IMR case in writing, and in layperson terms to the maximum extent practical, within 30 days of receiving the **Member's** request for IMR and supporting information. The time may be adjusted under any of the following circumstances:

- In the case of a review of Experimental or Investigational determination, if the **Member's** Provider determines that the proposed treatment or therapy would be significantly less effective if not promptly initiated. In this instance, the analysis and recommendations will be rendered within seven days of the request for expedited review. The review period can be extended up to three days for a delay in providing required documents at the request of the expert.
- In the case of a review where the Behavioral Health Services has not been provided and the **Member's** Provider or the Department of Managed Health Care certifies in writing that an imminent and serious threat to the **Member's** may exist, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of the **Member's** health. In this instance, any analyses and recommendation of the experts must be expedited and rendered within three days of the receipt of the **Member's** application and supporting information.
- If approved by the Department of Managed Health Care, the deadlines for the expert reviewers' analyses and recommendations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.
- The IRO will provide the Department of Managed Health Care, USBHPC, the **Member** and the **Member's** Provider with each of the experts' analyses and recommendations, and a description of the qualifications of each expert. The IRO will keep the names of the expert reviewers confidential, except in cases where the reviewer is called to testify and in response to court orders. In the case of an Experimental or Investigational determination, the experts' analyses will state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial to the **Member** than any available standard therapy and the reasons for recommending why the therapy should or should not be provided, citing the **Member's** specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the expert's recommendation.

The recommendation of the majority of the experts on the panel will prevail. If the experts on the panel are evenly divided as to whether the Behavioral Health Services should be provided, the panel's decision will be deemed to be in favor of coverage. If the majority of the experts on the panel does not recommend providing the Behavioral Health Services, USBHPC will not be required to provide the service.

When an Independent Medical Review Decision is Made

The Department of Managed Health Care will immediately adopt the decision of the IRO upon receipt and will promptly issue a written decision to the parties that will be binding on USBHPC. USBHPC will implement the

decision when received from the Department of Managed Health Care within five (5) working days. In the case of services not yet rendered to the **Member**, USBHPC will authorize the services within five working days of receiving the written decision from the Department of Managed Health Care, or sooner if appropriate for the nature of the **Member's** medical condition and will inform the **Member** and the **Member's** Provider of the authorization.

USBHPC will promptly reimburse the **Member** for reasonable costs associated with services that do not require prior authorization, urgently needed services or Emergency Services and Care outside of USBHPC's Provider network, if:

- The services are found by the IRO to have been Medically Necessary;
- The Department of Managed Health Care finds the **Member's** decision to secure services outside of USBHPC's Provider network prior to completing the grievance process or seeking IMR was reasonable under the circumstances; and
- The Department of Managed Health Care finds that the disputed health care services were a covered benefit under the Group Subscriber Agreement.

Behavioral Health Services required by IMR will be provided subject to the terms and conditions generally applicable to all other benefits under this Plan.

For more information regarding the IMR process, or to request an application, the **Member** should contact the Customer Service Department at 1-888-440-UCAL (8225).

The Quality Review Process

If a complaint is related to quality of care, the complaint will be reviewed under USBHPC's quality review process. The quality review process is a **Member** initiated internal review process that addresses **Member** concerns regarding the quality or appropriateness of services provided by a Participating Provider that has the potential for an adverse effect on the **Member**. Upon receipt of the **Member's** concern, the concern is referred to the Quality Improvement Department for investigation. Quality of care complaints that affect a **Member's** current treatment will be immediately evaluated and if necessary, other appropriate USBHPC personnel and the Participating Provider will be consulted.

The Quality Improvement Manager (or designee) will be responsible for responding to questions the **Member** may have about his or her complaint and about the Quality Review process. If indicated the relevant medical records will be obtained from the appropriate Providers and reviewed by the USBHPC Quality Improvement Manager (or designee). If necessary, a letter is sent to the Participating Provider, as appropriate, requesting further information. Additional information will be received and reviewed by the Quality Improvement Manager (or designee). After reviewing requested medical records, the case may be referred to the Peer Review Committee for review and recommendation of corrective action against the Participating Provider involved, if appropriate.

If the **Member** has submitted a complaint in writing, by telephone, or online, the **Member** will be notified of the completion in writing, within thirty (30) calendar days of receipt. If the grievance requires expedited review, the Member should receive a written statement on the disposition or pending status of the grievance no later than three (3) calendar days from receipt. The oral and written communications involving the Quality Review Process and the results of the review are considered confidential and cannot be shared with the **Member**. The Quality Improvement Manager will follow-up to ensure that any corrective actions against Contracted Provider are carried out.

Review by the Department of Managed Health Care

Members also have the right to a review by the California Department of Managed Health Care (DMHC). The DMHC is responsible for regulating health care services plans. If you have a

grievance against your health plan, you should first telephone your health plan at **1-888-440-UCAL (8225)** or **711 for TTY (at operator request, enter “1-888-440-8225”)** and use your health plan’s grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal right or remedies that may be available to you. If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatment that are experimental or investigational in nature and payment disputes for Emergency or Urgent medical services. The Department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department’s Internet Web site <http://www.dmhc.ca.gov> has complaint forms, IMR application forms and instructions online.

Glossary

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

Advanced Practice Registered Nurse

A registered nurse certified as a clinical nurse specialist pursuant California nursing requirements who participates in clinical practice in the specialty of psychiatric-mental health nursing.

Behavioral Health Services

Services and supplies that are:

- **Covered Services for Mental Health and Substance Abuse Treatment**
- Given while the **Member** is covered under the **Plan**.
- Rendered by one of the following providers - except that, where medically necessary, for the treatment of Severe Mental Illness or Serious Emotional Disturbance of a Child, services may be provided by other providers of care subject to applicable law:
 - **Physician**
 - **Psychologist**
 - **Licensed Counselor**
 - **Hospital/Facility**
 - **Treatment Center**
 - **Social Worker**
 - **Qualified Autism Service Provider, Qualified Autism Service Professional, or Qualified Autism Service Paraprofessional**
 - **Registered Mental Health Psychiatric Nurse**
 - **Advanced Practice Registered Nurse**

Behavioral Health Services include but are not limited to the following services provided through health care providers who are: (1) acting within the scope of their licensure; and (2) acting within their scope of competence, established by education, training and experience, to diagnose, and treat conditions pursuant to California Health and Safety Code Section 1374.72:

- Assessment
- Diagnosis

- Medication Management
- Individual, family and group psychotherapy and other psychotherapeutic methods
- Psychological testing
- Inpatient services, including **Hospital/Facility**-based treatment such as Acute Inpatient, Detoxification services, Residential Treatment, or Recovery Home treatment and any related Inpatient Professional Services
- Voluntary psychiatric inpatient services from licensed mental health providers including, but not limited to psychiatrists and psychologists
- Outpatient services, including treatment planning, biofeedback, intensive outpatient services, partial hospitalization/day treatment services, and methadone maintenance
- Behavioral health treatment for pervasive developmental disorders and autism
- Medically Necessary treatment for all Severe Mental Illness of a person of any age or Serious Emotional Disturbance of a child.
- **Telehealth** - no face-to-face contact is required between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the Plan.
- Crisis intervention and stabilization

Calendar Year

A period of one year beginning with January 1

Medically Necessary

An intervention recommended by the treating Practitioner and determined by the Medical Director of USBHPC to be all of the following:

- A health intervention for the purpose of **Mental Health and Substance Abuse Treatment**;
- The most appropriate level of service or item, considering potential benefits and harms to the Member;
- Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and
- If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. “Cost-effective” does not necessarily mean lowest price.

A service or item will be covered if it is an intervention that is an otherwise covered category of service or item, not specifically excluded and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medically Necessary.

In applying the above definition of Medically Necessary, the following terms shall have the following meaning:

- *Treating Practitioner* means a provider who has personally evaluated the patient. For these purposes, a “provider” includes but is not limited to one of the eligible behavioral health providers listed in the definition of Behavioral Health Services.
- *A health intervention* is Mental Health and Substance Abuse Treatment delivered or undertaken primarily to treat (that is, prevent, diagnosis, detect, treat or palliate) a behavioral health disorder, psychological injury, or substance abuse addiction, or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the condition and the patient indications for which it is being applied.
- *Effective* means that the intervention can reasonably be expected to produce the intended result and to have expected benefits that outweigh potential harmful effects.
- *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily

as perceived by the patient) of a person's life.

- *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the condition or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medically Necessary in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.
- A *new intervention* is one that is not yet in widespread use for the condition and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.
- An intervention is considered *cost-effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. The application of this criterion is to be on an individual case and the characteristics of the individual patient shall be determinative.

Course of Treatment

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

- Thirty (30) days with respect to treatment for substance abuse
- Six (6) months with respect to treatment for mental illness

Covered Expenses

The **Reasonable Charge** for **Mental Health and Substance Abuse Services** provided.

Member

- A **Member** is a properly enrolled Employee/Retiree and his/her properly enrolled Family Members.

Covered Services

Those services and supplies provided for the purpose of preventing, diagnosing or treating a behavioral health disorder, psychological injury or substance abuse addiction and which is described in the section titled **What This Plan Covers**, and not excluded under the section titled **What's Not Covered-Exclusions**.

Emergency Services and Care

An additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a **Psychiatric Emergency Medical Condition** exists, and the care and treatment necessary to relieve or eliminate the **Psychiatric Emergency Medical Condition**, within the capability of the facility. The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital or to an acute psychiatric hospital.

Health Care Provider

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

Hospital/Facility

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons that provides one or more Acute Inpatient, Detoxification services, Residential Treatment or Recovery Home treatment service, as appropriate, and is:

- Accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- Approved by **Medicare** as a hospital.
- 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.
- Licensed by the California State Department of Health Services or it operates under a waiver of licensure granted by the California State Department of Mental Health.

Participating Provider (also referred to as USBHPC Network)

A provider who participates in USBHPC's network.

Inpatient Treatment

Hospital/Facility-based treatment such as Acute Inpatient, Detoxification services, Residential Treatment or Recovery Home treatment and related Inpatient Professional Services.

Licensed Counselor

A person who specializes in Mental Health and Substance Abuse Treatment and is licensed as a Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), or Licensed Marriage and Family Therapist (LMFT) by the appropriate authority.

Medicare

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

Mental Health and Substance Abuse Treatment

Mental health and/or substance abuse treatment for the following:

- Any sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) other than those shown in the **What's not Covered – Exclusions** section, 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.
- Specifically Covered Services shall include the diagnosis and **Medically Necessary** treatment of Severe Mental Illness, which shall include the following conditions:
 - Schizophrenia

- Schizoaffective disorder
 - Bipolar disorder (manic- depressive illness)
 - Major depressive disorders
 - Panic disorder
 - Obsessive-compulsive disorder
 - Behavioral health treatment for pervasive developmental disorder or autism
 - Anorexia nervosa
 - Bulimia nervosa
- In addition, diagnosis and **Medically Necessary** treatment of Serious Emotional Disturbances of a child shall be covered services and shall specifically include any mental disorder identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms.
 - If prescribed as **Medically Necessary** for an enrollee with pervasive developmental disorder or autism, behavioral health treatment, meaning professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of the enrollee.

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 Diagnostic and Statistical Manual of Mental Disorders (other than those shown in the **What's not Covered – Exclusions** section), are considered **Mental Health and Substance Abuse Treatment**, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness which is identified in the Diagnostic and Statistical Manual of Mental Disorders (other than those shown in the **What's not Covered – Exclusions** section) is considered Mental Health and Substance Abuse Treatment.

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

Prescription Drugs may be part of **Mental Health and Substance Abuse Treatment** but they are not covered under this Plan. Prescription drugs prescribed by your provider may be covered under your prescription drug benefit.

Non-Routine Outpatient Treatment (see also Routine Outpatient Treatment)

These services include, but are not limited to, psychological testing, outpatient ECT (electro-convulsive therapy), extended length therapy sessions (more than 50 minutes in duration, with or without medication management), biofeedback, treatment planning, behavioral health treatment services for pervasive developmental disorders and autism, Structured/Intensive Outpatient Program treatment, Partial Hospitalization/Day Treatment, and methadone maintenance.

Non-Participating Provider

A provider who does not participate in USBHPC's network.

Physician

A legally qualified:

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

Plan

The group policy or policies issued by USBHPC which provide the benefits described in this Evidence of Coverage and Disclosure Form.

Provider

A person who is qualified and duly licensed, certified, or otherwise authorized pursuant to state law to furnish **Mental Health and Substance Abuse Treatment** independently without supervision, or where

required by state law, under the supervision of an independently practicing provider who employs the person.

Psychiatric Emergency Medical Condition

A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: a) an immediate danger to himself or herself or to others; b) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

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.

Recovery Home

Also called sober living arrangements are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment, and support for recovery from alcohol or drug use.

Residential Treatment

A sub-acute facility-based program which delivers 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment to members who do not require the intensity of nursing care, medical monitoring and physician availability offered in Inpatient. The course of treatment in a Residential Treatment Center is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care.

Qualified Autism Service Provider

Either of the following:

- A person, who is certified by a national entity, such as, the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.
- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Professional

An individual who meets all of the following criteria:

- Provides Behavioral Health Treatment which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider
- Is supervised by a **Qualified Autism Service Provider**
- Provides treatment pursuant to a treatment plan developed and approved by the **Qualified Autism Service Provider**
- Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of title 17 of the California Code of Regulations for an associate behavior analyst, behavioral analyst, behavior management assistant, behavior management consultant, or behavior management program
- Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code
- Is employed by a Qualified Autism Service Provider or entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Paraprofessional

An unlicensed and uncertified individual who meets all of the following criteria:

- Is supervised by a **Qualified Autism Service Provider** or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the **Qualified Autism Service Provider**
- Meets the education and training qualifications described in Section 54342 of title 17 of the California Code of Regulations.
- Has adequate education, training, and experience, as certified by a Participating **Qualified Autism Service Provider** or entity or group that employs Qualified Autism Service Providers.
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Reasonable Charge

As to charges for services rendered by or on behalf of a Participating **Provider** 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. 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 Mental Health Psychiatric Nurse

A registered nurse licensed pursuant to California requirements who possesses a master's degree in psychiatric-mental health nursing and two years of supervised experience in psychiatric-mental health nursing, and is recognized as a psychiatric mental health nurse by the California State Board of Registered Nurses.

Registered Nurse

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

Retiree

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

Retrospective Review

Retrospective Review is the process where treatment is reviewed to determine if it meets medical necessity guidelines for coverage after the treatment has already taken place.

Routine Outpatient Treatment (See also Non-Routine Outpatient Treatment)

A less intensive treatment alternative to **Inpatient** care. **Routine Outpatient Treatment** includes initial evaluations (diagnostic interviews) and medication evaluations, individual, family, and group counseling sessions up to 50 minutes and medication management visits with a mental health and substance abuse professional.

Social Worker

A social worker who has a clinical social worker license issued under California social work requirements.

Substance Abuse Rehabilitation

Treatment for a substance abuse disorder in a twenty-four (24) hour setting, or other setting outside of

an acute care **Hospital** that is licensed to perform that service and where there is no danger of medical complications due to detoxification.

Telehealth

The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications rather than in-person with the provider that is over a secured connection as required by applicable policies and federal and state law (including HIPAA).

Telephonic Counseling

Consultation and/or therapy performed over the telephone with a **Member** by a mental health or substance abuse professional.

Treatment Center

A facility which provides a program of effective **Mental Health and Substance Abuse 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**.

Urgent Care is care or treatment, the delay of which could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or -- in the opinion of a physician with knowledge of the claimant's medical condition -- would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

Utilization Review

A review and determination by USBHPC as to which services and supplies are **Covered Services**.

End of Evidence of Coverage

Attachment – A

Other Disclosures & Department of Managed Health Care Information

California Assembly Bill 72 Notification: In some cases, a non-plan provider may provide covered services at an in-network facility where we have authorized you to receive care. You are not responsible for any amounts beyond your cost share for the covered services you receive at plan facilities or at Participating facilities where we have authorized you to receive care. If you have any questions please follow the instructions in section “What to Do If You Have a Problem.”

Complaint or Grievance Process: On receipt of a grievance or complaint the Plan will send a written acknowledgement within five (5) calendar days of receipt. The acknowledgment will advise you that the grievance has been received, the date of receipt, and provide the name of the Plan representative, telephone number and address of the Plan representative who may be contacted about the grievance. If your grievance requires an expedited review, you will receive a written statement on the disposition or pending status of the grievance no later than three days from receipt. For all other complaints or grievances the Plan will resolve within thirty (30) days and notify you of the outcome.

**MEMBERS HAVE THE RIGHT TO FILE A GRIEVANCE AGAINST YOUR HEALTH PLAN.
MEMBERS SHOULD FIRST CONTACT USBHPC:**

P.O. BOX 30512
SALT LAKE CITY, UT 84130-0512
1-888-440-UCAL (8225)
www.liveandworkwell.com.

CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (DMHC):

Help Center
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
1-800-466-2219 (telephone)
1-916-255-5241 (fax)
<http://www.dmhc.ca.gov/>

**California Department of Managed Health Care Notification
Grievance Process and Independent Medical Review**

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-888-440-UCAL (8225)** or **711 for TTY (at operator request, say “1-888-440-8225”)** and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **<http://www.dnhc.ca.gov>** has complaint forms, IMR application forms and instructions online.

FOR ANY OTHER CONCERNS, PLEASE CONTACT USBHPC ON THE UC-DEDICATED
LINE: (888) 440-UCAL (8225)