

# **UNIVERSITY OF CALIFORNIA**

**Behavioral Health Benefits for  
Health Net Blue & Gold,  
Kaiser Permanente – California  
and Western Health Advantage Members**

**January 1, 2018**

**Insured by**

**Unimerica Life Insurance Company**

**(called the “Company”)**

**Administered by:**



**(Optum is the brand under which United Behavioral Health now operates)**

# Table of Contents

## Certification

<b>Schedule of Benefits .....</b>	<b>1</b>
Effective Date of this Plan .....	1
Behavioral Health Benefits .....	1
<b>Eligibility, Enrollment and Termination Provisions .....</b>	<b>3</b>
<b>Behavioral Health Benefits.....</b>	<b>3</b>
What This Plan Covers .....	3
Preauthorization Requirement and Utilization Review .....	5
Emergency Services and Care .....	5
Copayments .....	6
Out-of-Pocket Feature.....	6
Individual Out-of-Pocket Maximum.....	6
Family Out-of-Pocket Maximum.....	6
What’s Not Covered - Exclusions.....	6
In-Network Provider Charges Not Covered.....	8
<b>Claims Information.....</b>	<b>9</b>
How to File a Claim.....	9
When Claims Must be Filed .....	10
How and When Claims are Paid.....	10
Benefit Determinations.....	11
Appeal Process .....	13
Appeals Determinations.....	13
Independent Medical Review .....	14
Legal Actions.....	14
Incontestability of Coverage .....	14
Information and Records .....	14
<b>Coordination of Benefits .....</b>	<b>15</b>
Definitions .....	15
How Coordination Works.....	16
Which Plan Pays First.....	16
Facility of Payment.....	17
Right of Recovery.....	17
<b>Recovery Provisions.....</b>	<b>17</b>
Refund of Overpayments .....	17
Reimbursement of Benefits Paid .....	17
Subrogation.....	17
<b>Effect of Government Plans .....</b>	<b>18</b>
<b>What to Do If You Have a Problem .....</b>	<b>18</b>
<b>Glossary .....</b>	<b>23</b>
<b>IMPORTANT NOTICES .....</b>	<b>30</b>

---

# Certification

## INSURANCE BOOKLET

for Employees and Retirees of the

## UNIVERSITY OF CALIFORNIA

and its affiliates (and their Eligible Family Members)

(referred to as the University of California, University, UC or Employer)

insured by

## UNIMERICA LIFE INSURANCE COMPANY

Milwaukee, Wisconsin  
(called the Company)

## CERTIFICATE OF INSURANCE

Unimerica Life Insurance Company has issued Group Policy No. GA-11280. It covers certain Employees/Retirees of the University.

The policy provides behavioral health benefits.

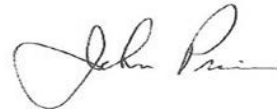
This Certificate of Insurance ("Certificate") describes the benefits and provisions of the policy.

This is a Covered Person's Certificate of Insurance only while that person is insured under the policy. Dependents' benefits apply only if the Employee/Retiree is insured under the University's plan for Dependent Benefits.

This Certificate describes the Plan in effect as of January 1, 2018.

This Certificate replaces any and all Certificates previously issued for Employees under the Plan.

UNIMERICA LIFE INSURANCE COMPANY



John M. Prince  
President

The behavioral health benefits described in this Plan are administered by Optum, the brand under which United Behavioral Health ("UBH") now operates.

**(888) 440-UCAL (8225)**

**Schedule of Benefits**

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

Effective Date of this Plan                      January 1, 2018

**Behavioral Health for Health Net, Kaiser Permanente California, and Western Health Advantage  
Non-Medicare Members**

Covered Services	In-Network <sup>1</sup> Providers Member Cost Sharing
<b>CALENDAR YEAR DEDUCTIBLE</b>	
Individual	\$0
Family	\$0
<b>ANNUAL OUT-OF-POCKET MAXIMUMS (INCLUDES DEDUCTIBLES)<sup>2</sup></b>	
Individual	\$1,000
Family	\$3,000
<b>ANNUAL BENEFIT MAXIMUMS</b>	
Mental Health	None
Substance Abuse	None
<b>LIFETIME BENEFIT MAXIMUMS</b>	
Mental Health	None
Substance Abuse	None
<b>MENTAL HEALTH / SUBSTANCE USE</b>	
<b>Routine Outpatient Visits<sup>3</sup></b> Visits 1-3 Visits 4+	No copay \$20 copay
<b>Non-Routine Outpatient Visits<sup>4</sup></b>  Psychological Testing, Outpatient Electro-convulsive therapy, extended length therapy sessions, biofeedback, Applied Behavior Analysis, methadone maintenance  Structured/Intensive outpatient program treatment  Partial Hospitalization/Day treatment  <b>Inpatient Treatment<sup>5</sup></b>  <b>Emergency Services and Care<sup>6</sup></b> Outpatient Hospital Emergency Room Services  Ambulance	Visits 1-3 No copay Visits 4+ \$20 copay  No copay  No copay  \$250 copay per admission/ course of treatment  \$75 copay (waived if admitted)  No copay

<sup>1</sup> To be covered at the In-Network benefit level, services must be Clinically Necessary and provided by an Optum In-Network clinician. Covered services other than Routine Outpatient Treatment and emergency treatment must be preauthorized (see "Preauthorization Requirement and Utilization Review" section in the Certificate for further information) in order to be covered. If treatment requiring preauthorization is not preauthorized, it will not be covered.

<sup>2</sup> Health Net and WHA members may use covered In-Network Mental Health, Substance Use, Medical, and Pharmacy expenses to satisfy the In-Network Out-of-Pocket Maximums. Kaiser members may use covered In-Network Mental Health and Substance Use expenses to satisfy the In-Network Out-of-Pocket Maximums. 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. Kaiser members should refer to their Kaiser plan Evidence of Coverage to learn how using Kaiser's Mental Health benefits will satisfy Kaiser's combined Out-of-Pocket Maximum for both Medical and Mental Health/Substance Abuse expenses and for other differences in the terms and conditions of that plan's coverage.

<sup>3</sup> 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.

<sup>4</sup> 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.

<sup>5</sup> 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.

<sup>6</sup> The Company will pay for Emergency Services and Care services regardless of the Provider's contract status with the Company. The plan will reimburse these Covered Expenses to ensure the member's liability is limited to the cost-share (e.g. copayment or coinsurance) of the In-Network benefit level. 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 out-of-network providers should be submitted online at [www.liveandworkwell.com](http://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.

### Employees

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

### Retirees

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

---

## Behavioral Health Benefits

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

### What This Plan Covers

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

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

There are certain In-Network **Non-Routine Outpatient** services that require preauthorization; see the 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 Requirement and Utilization Review**.

Each **Covered Person** 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 **Covered Person** 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 **Covered Person** 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, Professional, 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.
- **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.)

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 next section for further information about **Emergency Services and Care**. Optum 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.

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), 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.

If the **Covered Person** does not contact Optum for an authorization for treatment before **Behavioral Health Services** are provided, benefits under this **Plan** may be reduced as follows:

- **Non-Routine Outpatient** services not preauthorized are subject to **Utilization Review** and may not be covered if it is determined they were not **Medically Necessary**.
- All services may be subject to review at the time a claim is submitted for payment in order to determine if the services are eligible for payment as Covered Services including **Utilization Review** to verify that the claim for payment is for **Medically Necessary Covered Services**.

Optum performs a **Utilization Review** to determine whether the service or supply is a **Covered Service** as defined by this **Plan**. The **Covered Person** and his/her provider decide which **Behavioral Health Services** are given, but this **Plan** only pays for **Covered Services**.

When preauthorization is required, initial authorization decisions for urgent services are 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 **Covered Person** and provider/facility within two (2) business days of the decision, not to exceed seventy-two (72) hours from the time of the request.

When preauthorization is required, initial authorization determinations for non-urgent services are made within five (5) business days of receipt 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 **Covered Person** and provider/facility, within two (2) business days of the decision.

### **Emergency Services and Care**

**Emergency Services and Care** do not require a referral from Optum to an Optum **In-Network Provider**.

When **Emergency Services and Care** is required for Mental Health and Substance Abuse Treatment, the **Covered Person** (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. The Company will pay for **Emergency Services and Care** services regardless of the **Provider's** contract status with the Company. The plan will reimburse these **Covered Expenses** to ensure the member's liability is limited to the cost-share (e.g. copayment or coinsurance) of the In-Network benefit level.

When the **Emergency Services and Care** has ended, the **Covered Person** must get a referral from Optum before any additional services will be covered at the **In-Network** level. If the **Covered Person** does not get a referral as required, any additional services may not be covered.



The **Plan** will pay for all **Covered Services** rendered to a **Covered Person** prior to stabilization of the **Covered Person's Emergency Services and Care**, or during periods of destabilization when the **Covered Person** needs immediate **Emergency Services and Care**. **Covered Persons** 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 **Covered Person** must satisfy certain Copayment requirements. The amount of each Copayment is shown in the **Schedule of Benefits**.

Copayment is the amount of **Covered Expenses** the **Covered Person** 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 **In-Network** 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 **Covered Person** and the **Covered Person'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 **Covered Person's Provider** and/or are the only available treatment options for the **Covered Person's** condition. The exclusions or limitations described below shall not apply to any treatment services for a Severe Mental Illness or Serious Emotional Disturbance of a Child if and when those services medically necessary.

This **Plan** does not cover services, supplies or treatment relating to, arising out of, or given in connection with the following:

- Gambling Disorder, Neurological Disorders and other conditions with physical basis (e.g. Dementia), Impulse Control Disorder, Sleep Wake Disorder, any "Unspecified Forms" of Disorders, and Binge Eating Disorder.
- 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 Optum's Level of Care Guidelines or best practices as modified from time to time. Optum 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 except where the treatment goals and objectives for such behavioral treatments have been achieved or are no longer appropriate.

- 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 Optum. 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 Optum. 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.
- 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 **Covered Person** has the right to appeal through the **Independent Medical Review** process as described herein.
- Custodial Care except for the acute stabilization of the **Covered Person** and returning the **Covered Person** 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 **Covered Person'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 **Covered Person** to function outside a structured environment. This applies to **Covered Persons** 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.
- Nutritional Counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.
- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- 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 Optum has authorized the expenses in advance (or retrospectively in an emergency) for a **Covered Person** 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 **Covered Person**.
- **Behavioral Health Services** for which the **Covered Person** 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 **Covered Person** being eligible for coverage under the **Plan** or after the date the **Covered Person's** coverage under the **Plan** ends.

- **Telephonic counseling**, therapy performed over the telephone with a **Covered Person** by a mental health or substance abuse professional.

#### **In-Network Provider Charges Not Covered**

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

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

A **Covered Person** may reach an agreement with the **In-Network Provider** to pay for services and supplies which are not **Covered Services** and therefore are not covered by this **Plan**. In this case, the **In-Network Provider** may ask the **Covered Person** 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 Company.

---

## **Claims Information**

### **How to File a Claim**

When an **In-Network Provider** is used, the **In-Network Provider** will submit the claim on behalf of the **Covered Person**. All payments for In-Network Services will be paid directly to the **In-Network Provider**.

When an **Out-of-Network Provider** is used, the **Out-of-Network Provider** will generally require payment in advance and will not agree to file a claim for reimbursement. **Covered Persons** filing claims are urged to file them electronically; claims filed electronically are processed the most quickly. For instructions how to do this, go online to [www.liveandworkwell.com](http://www.liveandworkwell.com), enter access code 11280 and click on Submit Claims Online or Your Benefits & Programs.

If filing claims electronically is not possible, following are the instructions as to how to submit claims for reimbursement of Covered Expenses incurred with **Out-of-Network Providers**.

Claim forms are available in two ways: it can be downloaded online at [www.liveandworkwell.com](http://www.liveandworkwell.com), access code 11280 (note the address where to send the claim is at the top of the form and there are instructions "How to file a claim" on that site), or requested from Optum at (888) 440-UCAL (8225) If a claim form is requested but not received within 15 days, a Covered Person may file a claim without it by sending the bill with a letter that includes all the information listed below.

The Employee/Retiree portion of the form should be completed by the **Covered Person**; the **Out-of-Network Provider** portion should be completed by the **Out-of-Network Provider**. Once the form is completed it and any bills should be mailed to:

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

All payments for services and supplies received from an **Out-of-Network Provider** will be paid directly to the Employee/Retiree unless the Employee/Retiree "assigns" the payments to the **Provider** when completing the claim form.

In the event a **Covered Person** 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 **In-Network** benefit level based on the rate of exchange on the date that services are rendered. To process the claim, a complete billing statement is required. This

billing statement can be combined with a receipt for services. The statement must include the following:

- The Employee/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**

The submission of a claim form either electronically or by mail is necessary to receive payment for the benefits under this plan. The claim may be filed by you or the provider of service. The fully completed claim form must be submitted online or sent to the proper address within 90 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, Optum is not liable for the payment of benefits under this agreement if claims are not filed within the required time period.

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

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

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

The Company will reimburse claims or any portion of any claim for **Covered Expenses**, as soon as possible, not later than 30 working days after receipt of the claim. However, a claim or portion of a claim may be contested by the Company. In that case the **Covered Person** will be notified in writing that the claim is contested or denied within 30 working days of receipt of the claim. The notice that the claim is being contested will identify the portion of the claim that is contested and the specific reasons for contesting the claim. If an uncontested claim is not reimbursed by delivery to the 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**

Optum will make a benefit determination as set forth below. Benefits will be paid to the covered Employee/Retiree as soon as Optum 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, Optum will make payments directly to the **Provider** of care.
- If Optum pays benefits directly to **In-Network 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 the Company's obligation to the extent of the payment.

Optum will send an Explanation of Benefits (EOB) to the covered Employee/Retiree. The EOB will explain how Optum considered each of the charges submitted for payment. If any claims are denied or denied in part, the 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 **Covered Person's** claim was a pre-service claim, and was submitted properly with all needed information, the **Covered Person** will receive written notice of the claim decision from Optum within 15 days of receipt of the claim. If the **Covered Person** filed a pre-service claim improperly, Optum will notify the **Covered Person** of the improper filing and how to correct it within five days after the pre-service claim was received. If additional information is needed to process the pre-service claim, Optum will notify the **Covered Person** of the information needed within 15 days after the claim was received, and may request a one-time extension not longer than 15 days and pend the **Covered Person's** claim until all information is received. Once notified of the extension, the **Covered Person** then has 45 days to provide this information. If all of the needed information is received within the 45-day time frame, Optum will notify the **Covered Person** of the determination within 15 days after the information is received. If the **Covered Person** does not provide the needed information within the 45-day period, the claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

#### **Concurrent Care Claims**

Concurrent Care Claims are claims filed for payment while **Mental Health and Substance Abuse Services** are being provided. If an ongoing **Course of Treatment** was previously approved for a specific period of time or number of treatments, and the request to extend the treatment is an urgent claim as defined below, the **Covered Person's** request will be decided upon within 24 hours, provided the request is made at least 24 hours prior to the end of the approved treatment. Optum will make a determination on the request for the extended treatment within 24 hours from receipt of the request. If the request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent claim and decided according to the timeframes described below.

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

### **Post-service Claims**

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

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

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

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

**Urgent Care** claims are those claims that require authorization or a benefit determination for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations 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 that is the subject of the claim.

In these situations:

- The **Covered Person** will receive notice of the benefit determination within 24 hours after Optum receives all necessary information, taking into account the seriousness of the **Covered Person's** condition. Written notice of decisions resulting in denial, delay, or modification of the request for **Urgent Care** is transmitted to the **Covered Person** and provider/facility within two (2) business days of the decision, not to exceed seventy-two (72) hours from the time of the request.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

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

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

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

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

### **Questions or Concerns about Benefit Determinations**

If the **Covered Person** has a question or concern about a benefit determination, he or she may informally

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

A **Covered Person** has the right to appeal any determination of the plan or insurer which purports to rescind coverage under the policy/plan.

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

### **How to Appeal a Claim Decision**

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

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

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

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

Optum Appeals  
P.O. Box 30512  
Salt Lake City, UT  
84130-0512  
[www.liveandworkwell.com](http://www.liveandworkwell.com)  
1-888-440-UCAL (8225)

### **Appeal Process**

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal.

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

### **Appeals Determinations**

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

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



For appeals of **Pre-Service Claims** as identified above, the appeal will be conducted and the **Covered Person** will be notified of the decision within 15 days from receipt of a request for appeal of a denied claim.

For appeals of **Post-Service Claims** as identified above, the appeal will be conducted and the **Covered Person** will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim.

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

If the **Covered Person** is not satisfied with the appeal decision, he or she has the right to request an **Independent Medical Review** as described below.

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

Please note that Optum'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 **Covered Person's** health or the ability to regain maximum function. In these urgent situations:

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

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

### **Legal Actions**

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

### **Incontestability of Coverage**

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

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

### **Information and Records**

At times the Company may need additional information from the **Covered Person**. The **Covered Person** must agree to furnish the Company with all information and proofs that it may reasonably require regarding any matters pertaining to the Policy. If the **Covered Person** does not provide this information when the Company requests it, the Company may delay or deny payment of benefits.

By accepting the **Mental Health and Substance Abuse Services** under the **Plan**, the **Covered Person** authorizes and directs any person or institution that has provided services to him/her to furnish the Company with all information or copies of records relating to the services provided to the **Covered Person**. The Company has the right to request this information at any reasonable time. This applies to all **Covered Persons**, including Dependents whether or not they have signed the Employee enrollment form.

The Company agrees that such information and records will be considered confidential.

The Company 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 the Company is required to do by law or regulation. During and after the term of the **Plan**, the Company 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 **Covered Person's** medical records or billing statements, the Company recommends that the **Covered Person** contact his/her **Provider**. **Providers** may charge reasonable fees to cover their costs for providing records or completing requested forms.

If the **Covered Person** requests medical forms or records from the Company, the Company also may charge the

**Covered Person** reasonable fees to cover costs for completing the forms or providing the records.

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

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

---

## Coordination of Benefits

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

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

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

### **Definitions**

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

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

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

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

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

The difference between the cost of a private hospital room and the cost of a semi-private hospital room

is not considered an Allowable Expense unless the patient's stay in a private hospital room is **Medically Necessary** either in terms of generally accepted medical practice, or as defined in the plan.

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

#### **How Coordination Works**

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

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

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

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

#### **Which Plan Pays First**

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

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- 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 **Covered Person**

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

#### **Right of Recovery**

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

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

---

## **Recovery Provisions**

#### **Refund of Overpayments**

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

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

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

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

#### **Reimbursement of Benefits Paid**

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

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

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

#### **Subrogation**

In the event a **Covered Person** suffers an injury or sickness as a result of a negligent or wrongful act or

omission of a third party, the Company has the right to pursue subrogation where permitted by law.

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

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

---

## **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 **Covered Person** 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 **Covered Person** under the Government Plan.

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

---

## **What to Do if You Have a Problem?**

If you ever have a question or problem, your first step is to call the Customer Service Department for resolution. If you feel the situation has not been addressed to your satisfaction, you may submit a formal grievance (also referred to as a “complaint” or “appeal”) within 180 days of your receipt of an initial determination in writing, online, or by telephone:

Optum Appeals  
P.O. Box 30512  
Salt Lake City, UT  
84130-0512  
[www.liveandworkwell.com](http://www.liveandworkwell.com)  
1-888-440-UCAL (8225)

### **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 **Covered Person** may obtain, upon request and free of charge, copies of all documents, records, and other information relevant to the **Covered Person'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.

An Optum 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.

## **Expedited Review Process**

Appeals involving an imminent or serious threat to the health of the **Covered Person**, including, but not limited to, severe pain, potential loss of life, limb or other major bodily functions will be immediately referred to the Optum Medical Director for expedited review, regardless of whether such appeal is received orally or in writing. If an appeal has been sent to the Optum Medical Director for immediate expedited review, Optum will immediately inform the **Covered Person**, of his or her right to notify the Department of Managed Health Care with a written statement of the disposition or pending status of the expedited review no later than three (3) 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 **Covered Person** may request an Independent Medical Review (IMR) of disputed **Behavioral Health Services** from the California Department of Insurance (CDI) if the **Covered Person** believes that **Behavioral Health Services** have been improperly denied, modified or delayed by Optum. A “disputed Behavioral Health Service” is any **Behavioral Health Service** eligible for coverage that has been denied, modified or delayed, in whole or in part because the service requested by you or your Provider based on a finding that the requested 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 **Covered Person** 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 CDI. The **Covered Person** pays no fee to apply for IMR. The **Covered Person** has the right to include any additional information or evidence not previously provided to Optum in support of the request for IMR. Optum will provide the **Covered Person** with an IMR application form with any grievance disposition letter that denies, modifies or delays Behavioral Health Services. The **Covered Person** may also reach the CDI by calling 1-800-927-HELP (1-800-927-4357).

A decision not to participate in the IMR process may cause the **Covered Person** to forfeit any statutory right to pursue legal action against Optum 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 Optum is not responsible for the payment of services rendered by non-Participating Providers who are not otherwise covered under your benefits.)

3. An Optum Medical Director has denied your request for a treatment or therapy recommended or requested pursuant to the above paragraph.
4. The treatment or 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, Optum 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 from the CDI. (Please note that you may request an IMR, if your request for Experimental or Investigational therapy is denied, without going through the Optum 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 Optum 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 CDI for IMR of a Disputed Behavioral Health Service if you meet all of the following criteria:

- The **Covered Person**'s Provider has recommended a Behavioral Health Service as Medically Necessary; or
- The **Covered Person** has received Urgently Needed Services or Emergency Services that a Provider determined was Medically Necessary; or
- The **Covered Person** has been seen by an In-Network Provider for diagnosis or treatment of the medical condition for which the **Covered Person** 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 **Covered Person** has filed a grievance with Optum and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If the grievance requires expedited review, the **Covered Person** may bring it immediately to the CDI's attention. The CDI may waive the preceding requirement that the **Covered Person** follow Optum's grievance process in extraordinary and compelling cases.

### **Accepted Applications for the Independent Medical Review**

Upon receiving a **Covered Person**'s application for IMR, the CDI will review the request and notify the **Covered Person** whether the **Covered Person**'s case has been accepted. If the **Covered Person**'s case is eligible for IMR, the dispute will be submitted to an independent medical review organization (IRO) contracted with the CDI for review by one or more expert reviewers, independent of Optum, 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 **Covered Person**'s conditions, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither the **Covered Person** nor Optum will control the choice of expert reviews.

Optum must provide the following documents to the IRO within three business days of receiving notice from the CDI that the **Covered Person** has successfully applied for an IMR:

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

If there is an imminent and serious threat to the **Covered Person**'s health, Optum 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 **Covered Person** or the **Covered Person**'s Provider wish to submit to the CDI in support of IMR that was not previously provided to Optum, the **Covered Person** may include this information with the IMR application to the CDI. Also as required, the **Covered Person** or the **Covered Person**'s Provider must provide to the CDI or the IRO copies of any 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 **Covered Person**'s IMR case in writing, and in layperson terms to the maximum extent practical, within 30 days of receiving the **Covered Person**'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 **Covered Person**'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.
- If the Behavioral Health Services has not been provided and the **Covered Person**'s Provider or the CDI certifies in writing that an imminent and serious threat to the **Covered Person**'s life 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 **Covered Person**'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 **Covered Person**'s application and supporting information.
- If approved by the CDI, 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 CDI, Optum, the **Covered Person** and the **Covered Person**'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 **Covered Person** than any available standard therapy and the reasons for recommending why the therapy should or should not be provided, citing the **Covered Person'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, Optum will not be required to provide the service.

### **When an IMR Decision is Made**

The CDI 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 Optum. Optum implement the decision when received from the CDI within five working days. In the case of services not yet rendered to the **Covered Person**, Optum will authorize the services within five working days of receiving the written decision from the CDI, or sooner if appropriate for the nature of the **Covered Person's** medical condition and will inform the **Covered Person** and the **Covered Person's** Provider of the authorization.

Optum will promptly reimburse the **Covered Person** for reasonable costs associated with urgently needed services or Emergency Services and Care outside of Optum's Provider network, if:

- The services are found by the IRO to have been Medically Necessary;
- The CDI finds the **Covered Person's** decision to secure services outside of Optum's Provider network prior to completing the grievance process or seeking IMR was reasonable under the circumstances; and
- The CDI 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 **Covered Person** 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 Optum's quality review process. The quality review process is a **Covered Person**-initiated internal review process that addresses **Covered Person** concerns regarding the quality or appropriateness of services provided by an In-Network Provider that has the potential for an adverse effect on the **Covered Person**. Upon receipt of the **Covered Person's** concern, the concern is referred to the Quality Improvement Department for investigation. Quality of care complaints that affect a **Covered Person's** current treatment will be immediately evaluated and if necessary, other appropriate Optum personnel and the In-Network Provider will be consulted.

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

If the **Covered Person** has submitted a written complaint, the **Covered Person** will be notified of the completion in writing within thirty (30) days. The oral and written communications involving the Quality Review Process and the

results of the review are confidential and cannot be shared with the **Covered Person**. The outcome of the Quality Review Process cannot be submitted to voluntary mediation or binding arbitration as described above under the Optum Appeals Process. The Quality Improvement Manager will follow-up to ensure that any corrective actions against In-Network Provider are carried out.

### **Review by the Department of Managed Health Care**

**Covered Persons** also have the right to review 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-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department’s Internet Web site <http://www.hmohelp.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 **Covered Person** 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, Professional, 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
- **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.

### **Calendar Year**

A period of one year beginning with January 1.

### **Clinically Necessary**

Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are

- (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- (c) not primarily for the convenience of the patient or physician, or other physician.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, *Physician Specialty Society* recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors. For these purposes "physician" means all credentialed eligible behavioral health providers which include, but are not limited to, Clinicians, psychiatrists, nurse practitioners, social workers, family therapists, and developmental pediatricians.

### **Course of Treatment**

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

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

### **Covered Expenses**

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

### **Covered Person**

A **Covered Person** is a properly enrolled Employee/Retiree and his/her properly enrolled Family Members. Further detail can be found in the "Group Insurance Eligibility Fact Sheet for Employees and Eligible Family Members". A copy of this fact sheet is available in the HR Forms section of UCnet ([ucnet.universityofcalifornia.edu](http://ucnet.universityofcalifornia.edu)).

### **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.

**Employee**

This definition can be found in the “Group Insurance Eligibility Fact Sheet for Employees and Eligible Family Members”. A copy of this fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu).

**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 Acute Inpatient, Detoxification services, Residential Treatment or Recovery Home treatment and:

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

**In-Network Provider (also referred to as Network or Optum Network)**

A provider who participates in Optum'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.

**Medically Necessary**

See definition of “**Clinically Necessary.**”

**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 Substance Abuse Treatment is 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
  - 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.

#### **Out-of-Network Provider**

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

**Physician**

A legally qualified:

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

**Plan**

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

**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.

**Qualified Autism Service Provider**

Either of the following:

- A person, entity, or group that is certified by a national entity, such as, but not limited to, the Behavior Analyst Certification Board, 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, entity, or group that is nationally certified including **Qualified Autism Service Professionals** and **Qualified Autism Services Paraprofessionals** as defined by California law.
- 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 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
- Is employed and 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 approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavioral analyst, behavior management assistant, behavior management consultant, or behavioral management program as defined in Section 54342 of title 17 of the California Code of Regulations
- 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

**Qualified Autism Service Paraprofessional**

An individual who meets all of the following criteria:

- Is employed and supervised by a **Qualified Autism Service Provider**
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the **Qualified Autism Service Provider**
- Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the California Welfare and Institutions Code
- Has adequate education, training, and experience, as certified by a Participating **Qualified Autism Service Provider**

**Reasonable Charge**

As to charges for services rendered by or on behalf of an **In-Network 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 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 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 **Covered Person** 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 Optum as to which services and supplies are **Covered Services**.

**End of Certificate**



**IMPORTANT NOTICE**

**THIS PLAN IS REGULATED BY BOTH THE CALIFORNIA DEPARTMENT OF INSURANCE AND THE CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE. FOR UNRESOLVED DISPUTES REGARDING THIS PLAN, MEMBERS MAY PURSUE RESOLUTION THROUGH EITHER REGULATORY AGENCY.**

COVERED PERSONS HAVE THE RIGHT TO FILE A GRIEVANCE AGAINST YOUR HEALTH PLAN. COVERED PERSONS SHOULD FIRST CONTACT OPTUM:

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

IF THE DISPUTE IS NOT RESOLVED, COVERED PERSONS MAY USE EITHER THE DEPARTMENT OF MANAGED HEALTH CARE OR THE DEPARTMENT OF INSURANCE FOR ASSISTANCE. CONTACT INFORMATION FOR BOTH AGENCIES IS SHOWN BELOW.

**CALIFORNIA DEPARTMENT OF INSURANCE:**

State of California  
**Department of Insurance**  
Health Claims Bureau  
300 South Spring Street, South Tower  
Los Angeles, CA 90013  
<http://www.insurance.ca.gov>  
1-800-927-HELP (1-800-927-4357)  
1-800-482-4833 (TTY)

**CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE:**

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

<p><b>California Department of Managed Health Care Notification Grievance Process and Independent Medical Review</b></p>
------------------------------------------------------------------------------------------------------------------------------

<p>The California Department of Managed Health Care is responsible for regulating health care</p>
---------------------------------------------------------------------------------------------------

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-HMO-2219**) or (**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.hmohelp.ca.gov>** has complaint forms, IMR application forms and instructions online.

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

**ANOTHER IMPORTANT NOTICE CONCERNING CHANGES EFFECTIVE JANUARY 1, 2009  
IS ON THE FOLLOWING PAGE.**

## **English**

### **IMPORTANT LANGUAGE INFORMATION:**

You may be entitled to the rights and services below. These rights apply only under California law. However, these rights do not apply to all California residents. These rights do not apply to all languages.

You can get an interpreter to help you talk with your doctor or health plan. To get help in your language, please call your health plan at 1-800-999-9585 or call the number on your ID card.

Language services are at no cost to the enrollee. Written information may be available in some languages. If you need more help, call the DMHC Help Center at 1-888-466-2219.

## **Español**

### **INFORMACIÓN IMPORTANTE SOBRE EL IDIOMA:**

Usted puede tener derecho a los derechos y servicios que se indican a continuación. Estos derechos se aplican sólo bajo la ley de California. No obstante, estos derechos no se aplican a todos los residentes de California. Estos derechos no se aplican a todos los idiomas.

Puede obtener la ayuda de un intérprete para hablar con su médico o plan de salud. Para obtener ayuda en su idioma, llame a su plan de salud al 1-800-999-9585 o llame al número que se encuentra en su Tarjeta de Identificación (ID).

Los servicios en otros idiomas son gratuitos para el afiliado. Puede haber información escrita disponible en otros idiomas. Si necesita más ayuda, llame al Centro de Ayuda del DMHC al 1-888-466-2219.

(Spanish)

## **中文**

重要語言資訊：您可能擁有權下列權利並取得下列服務。這些權利僅按加州法律規定而適用。然而這些權利並不適用於所有加州居民。這些權利並不適用於所有語言。

您可以取得口譯員服務，協助您和醫師或健康計畫溝通。如需取得您的語言的協助，請撥打 1-800-999-9585 或會員卡背後的電話與您的健康計畫連絡。

計畫參加者不須支付語言服務費用。部分語言備有書面資訊。若您需要更多協助，請致電 DMHC 中心 1-888-466-2219。(Chinese)