

# **UNIVERSITY OF CALIFORNIA**

## **Behavioral Health Benefits for Kaiser Permanente – California Members**

### **Combined Evidence of Coverage / Disclosure Form**

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

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# Introduction

## WELCOME TO U.S. BEHAVIORAL HEALTH PLAN, CALIFORNIA

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

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

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

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

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

### **What if I still need help?**

After you become familiar with your behavioral health benefits, you may still need assistance. Please do not hesitate to call our Customer Service Department at [1-800-999-9585], or for the hearing and speech impaired dial 711 and at the operator's request, say or enter "[1-800-999-9585]".

You may write to USBHPC at the following address:

U.S. Behavioral Health Plan, California  
[P. O. Box 2839  
San Francisco, CA 94126]  
Or visit USBHPC's Web site:  
**[www.liveandworkwell.com](http://www.liveandworkwell.com)**

### **Important Language Information:**

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

You can get an interpreter in any of the top 15 languages spoken by limited English-proficient individuals at no cost to help you talk with your provider or health plan. USBHPC uses a telephone translation service for almost 140 languages and dialects. In addition to Customer Service representatives who are fluent in Spanish, translated Member materials are available upon request. Interpretation services are available at no charge to the member in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services. To get help in your language, please call your health plan at: U.S. Behavioral Health Plan, California at [1-800-999-9585] / TTY: 711. These services are available at no cost to you when filing a grievance with the Plan.

Language services and the availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, will be at no charge and provided in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities. For further assistance, please contact USBHPC at [800-999-9585].

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

### **Timely Access to Care**

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

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

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

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

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

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

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

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

contact USBHPC for assistance by calling [1-800-999-9585]. Additionally, the DMHC Help Center may be contacted at 1-888-466-2219 to file a complaint if you are unable to obtain a timely referral to an appropriate Participating Provider.

### **Choice of Physicians and Providers**

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

Call the USBHPC Customer Service Department for:

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

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

### **Facilities**

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

### **Non-Participating Providers**

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

### **NOTICE OF NON-DISCRIMINATION**

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

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

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

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

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

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

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

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

## **Compensating Participating Providers**

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

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

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

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

## **Confidentiality of Information**

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

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

A statement describing USBHPC's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you open request. If you would like a copy of USBHPC's confidentiality policies and procedures, you may call our Customer Service Department at [1-800-999-9585].

## **USBHPC Public Policy Participation**

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

## Schedule of Benefits

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

Effective Date of this Plan                      January 1, 2020

### Behavioral Health Benefits for Kaiser Permanente California Non-Medicare Members

Covered Services	Participating Providers Member Cost Sharing
<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	No copay
Visits 4+	\$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	Visits 1-3 No copay Visits 4+ \$20 copay
Structured/Intensive outpatient program treatment	No copay
Partial Hospitalization/Day treatment	No copay
<b>Inpatient Treatment<sup>5</sup></b>	\$250 copay per admission/ course of treatment
<b>Emergency Services and Care<sup>6</sup></b>	
Outpatient Hospital Emergency Room Services	\$75 copay (waived if admitted)
Ambulance	No copay

<sup>1</sup> To be covered, services must be Clinically Necessary and provided by a USBHPC Participating provider. Covered services other than Routine Outpatient Treatment and emergency treatment must be preauthorized (see "Preauthorization Requirement and Utilization Review" section in the Combined Evidence of Coverage and Disclosure Form for further information) in order to be covered. If treatment requiring preauthorization is not preauthorized, it will not be covered. <sup>2</sup> Kaiser members may use covered Mental Health and Substance Use expenses to satisfy the 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> USBHPC will cover Emergency Services and Care services regardless of the Provider's contract status with USBHPC. USBHPC will reimburse these Covered Expenses to ensure the member's liability is limited to the cost-share (e.g. copayment or coinsurance) of a participating provider. Emergency Services and Care is defined as an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, within the capability of the facility. The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital or to an acute psychiatric hospital.

**Note**

- Mental health/substance abuse claims for **Emergency Services and Care** with non-participating providers should be submitted online at [www.liveandworkwell.com](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]

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## 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, renewal, cancellation or termination of coverage and conversion options can be found in “A Complete Guide to Your UC Health and Welfare Benefits”. A copy is available on UCnet ([ucnet.universityofcalifornia.edu](http://ucnet.universityofcalifornia.edu)). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

### Retirees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the “Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members.” A copy of this fact sheet is available on UCnet ([ucnet.universityofcalifornia.edu](http://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.

### Important Information

- A Member who alleges that an enrollment or subscription under this Plan has been cancelled or not renewed because of the Member’s health status or requirements for health care services may request a review of the cancellation by the Director of the California Department of Managed Health Care (DMHC). Contact information for DMHC can be found in Attachment A.
- Coverage for an eligible child under this Plan will not terminate when they reach age 26 (the limiting age) if the child is and continues to meet both of the following criteria:
  - o Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition.
  - o Chiefly dependent upon the subscriber for support and maintenance.
- Reasons for disenrollment under the UC plan are established by the employer and are identified in the “Complete Guide to Your UC Health and Welfare Benefits” and the “Fact Sheet for Retirees and their Eligible Family Members”.
- An eligible adult under a same-gender or opposite-gender domestic partnership may be enrolled under the UC plan as defined in the “Complete Guide to Your UC Health and Welfare Benefits” and the “Fact Sheet for Retirees and Eligible Family Members” as located on [ucnet.universityofcalifornia.edu](http://ucnet.universityofcalifornia.edu).
- If an individual Member’s coverage terminates, they may have an opportunity for continuation of coverage as defined in the “Complete Guide to Your UC Health and Welfare Benefits” and the “Fact Sheet for Retirees and Eligible Family Members” as located on [ucnet.universityofcalifornia.edu](http://ucnet.universityofcalifornia.edu).

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## Behavioral Health Benefits

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

### What USBHPC Covers

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

The best way to ensure services will be covered is to call USBHPC at (888) 440-UCAL (8225) in advance

for preauthorization. Calling USBHPC will assure referral to the most appropriate treatment.

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

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

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

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

A **Covered Expense** is incurred on the date the **Behavioral Health Service** is provided. The **Covered Expense** is the actual cost to the **Member** of the **Reasonable Charge** for **Behavioral Health Services** provided. The Company will calculate **Covered Expenses** following evaluation and validation of all **Provider** billings in accordance with the methodologies:

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

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

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

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

- Assessment
- Diagnosis
- Medication Management
- Individual, family and group psychotherapy and other psychotherapeutic methods

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

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

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

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

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

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

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

#### **Preauthorization Requirements and Utilization Review**

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

**determinations are provided in the section of this EOC entitled, “Benefit Determinations”.**

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

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

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

**Non-Urgent Services:** When preauthorization is required for non-urgent services, the initial authorization determination is made within five (5) business days of receipt of the request. If the request is made by a provider or facility, the requesting provider or facility is notified of the authorization decision by telephone or facsimile within twenty-four (24) hours of the decision. Written notice of decisions resulting in denial, delay, or modification of the request for non-urgent care is sent to the **Member** and provider/facility, within two (2) business days of the decision.

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

#### **Notice of Right to Additional Information**

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

#### **Emergency Services and Care**

**Emergency Services and Care** do not require prior authorization.

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

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

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

stabilization care is deemed authorized if a decision to authorize or not cover care is not reached by USBHPC within one-half (1/2) hour of receipt of the request.

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

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

#### **Copayments**

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

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

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

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

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

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

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

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

#### **What's Not Covered - Exclusions**

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

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

- Gambling Disorder, Neurological Disorders and other conditions with physical basis (e.g. Dementia), Impulse Control Disorder, Sleep Wake Disorder, and any "Unspecified Forms" of Disorders.
- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), except as otherwise required or

provided for by law.

- Treatment or services that are medical in nature and covered under a medical plan.
- Outpatient prescription drugs or over-the-counter drugs and treatments. Outpatient prescription drugs prescribed by your provider may be covered under your prescription drug benefit.
- Services or supplies for Mental Health and Substance Abuse Treatment that are any of the following:
  - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
  - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
  - not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;
  - typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or
  - not consistent with USBHPC's Clinical Criteria or best practices as modified from time to time. USBHPC may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.

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

- For adults only, treatment or services, except for the initial diagnoses, for a primary diagnoses of Mental Retardation, Learning, Motor Skills, and Communication Disorders, Conduct Disorder, Dementia, Sexual and Paraphilia Disorders (other than Sexual Identity Disorder), and Personality Disorders, as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by USBHPC. This exclusion shall not be read or interpreted to exclude coverage for **Medically Necessary** treatment of pervasive developmental disorders or autism through behavioral health treatments.
- For children only, treatment or services, except for the initial diagnoses, for a primary diagnoses of Mental Retardation, Learning, Motor Skills, and Communication Disorders as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by USBHPC. This exclusion shall not be read or interpreted to exclude coverage for **Medically Necessary** treatment of pervasive developmental disorders or autism through behavioral health treatments. See the description of covered behavioral health treatment for pervasive developmental disorder or autism in this EOC in the listing of covered Behavioral Health Services.
- Unproven, Investigational or Experimental Services. These are services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a **Covered Service** if the service, treatment, or device is considered to be unproven, investigational, or experimental. In the event services are denied on the basis of this exclusion the **Member** has the right to appeal through the **Independent Medical Review** process as described herein.
- Custodial Care except for the acute stabilization of the **Member** and returning the **Member** back to his or her baseline levels of individual functioning except that this exclusion does not apply to **Medically Necessary** behavioral health treatment when prescribed for pervasive developmental disorders or autism. Custodial care does not include Acute Inpatient, Detoxification services, Residential Treatment, or Recovery Home treatment and related Inpatient Professional Services. Care

is determined to be custodial when:

- it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the **Member's** competent functioning in activities of daily living; or
  - it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the **Member** to function outside a structured environment. This applies to **Members** for whom there is little expectation of improvement in spite of any and all treatment attempts.
- Neuropsychological testing when used for the diagnosis of attention deficit disorder.
  - Examinations or treatment, unless it otherwise qualifies as a **Behavioral Health Service**, when:
    - required solely for purposes of career, education, sports or camp, travel, employment, insurance or adoption;
    - ordered by a court except as required by law;
    - conducted for purposes of medical research; or
    - required to obtain or maintain a license of any type.
  - Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
  - Services or treatment rendered by unlicensed **Providers**, except as may be authorized, permitted, or required by applicable law, including pastoral counselors, or which are outside the scope of the **Providers'** licensure. This exclusion does not apply to behavioral health treatment for pervasive developmental disorder or autism.
  - Personal convenience or comfort items including, but not limited to such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
  - Light boxes and other equipment including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
  - Private duty nursing services while confined in a facility.
  - Surgical procedures including but not limited to sex transformation operations.
  - Smoking cessation related services and supplies.
  - Travel or transportation expenses unless USBHPC has authorized the expenses in advance (or retrospectively in an emergency) for a **Member** to be transferred by ambulance to a mental health or substance abuse facility.
  - Services performed by a **Provider** who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the **Provider** may perform on himself or herself.
  - Services performed by a **Provider** with the same legal residence as the **Member**.
  - **Behavioral Health Services** for which the **Member** has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the **Plan**.
  - Charges in excess of any specified **Plan** limitations.
  - Any charges for missed appointments.



- Any charges for record processing except as required by law.
- Treatment or services received prior to **Member** being eligible for coverage under the **Plan** or after the date the **Members** coverage under the **Plan** ends.
- **Telephonic counseling**, therapy performed over the telephone with a **Member** by a mental health or substance abuse professional, except to the extent permitted by law.

#### **Participating Provider Charges Not Covered**

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

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

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

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## **Claims Information**

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

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

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

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

- The Employee/Retiree's name, Social Security Number, address and phone number.
- The patient's name.
- The Plan number (11280).
- The name, address and phone number of the Provider.
- The license level (for example, MD, PhD, LCSW, MFT, LPC, etc.) of the **Provider**.
- The date of service.
- The place of service.
- The specific services provided.
- The amount charged for the service.
- The diagnosis.

The claim/billing statement should be mailed to:

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

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

### **When Claims Must be Filed**

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

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

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

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

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

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

### **How and When Claims Are Paid**

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

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

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

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

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

- The surviving spouse.
- A Dependent child who is not a minor, if there is no surviving spouse.
- A **Provider** of care who makes charges to the covered Employee/Retiree's Dependents for **Behavioral Health Services**.
- The legal guardian of the covered Employee/Retiree's Dependent.

### **Benefit Determinations**

#### **Pre-Service Claims**

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

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

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

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

#### **Concurrent Care Claims**

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

If an ongoing **Course of Treatment** for inpatient and residential levels of care was previously approved for a specific period of time, the request will be decided upon and facility / clinician verbally notified within 24 hours from receipt of the request. The request must be made to USBHPC at least 24 hours prior to the end of the approved treatment. If the request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent claim and decided according to the timeframes described below.

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

### **Post-service Claims**

Post-service claims are those claims that are filed for payment of benefits after **Behavioral Health Services** have been received. If the **Member's** post-service claim is approved or denied, delayed or modified, he or she will receive a written notice from USBHPC within thirty (30) calendar days of receipt of the claim, as long as all needed information was provided with the claim. USBHPC will notify the Member within this 30-day period if additional information is needed to process the claim.

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

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

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

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

In these situations:

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

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

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

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

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

### **Notice of Right to Additional Information**

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

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

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

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

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

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

If the Member disagrees with a claim determination after following the above steps, he or she can contact USBHPC in writing, by facsimile, by telephone or online to formally request an appeal. If the appeal relates to a claim for payment, the request should include:

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

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

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

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

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

### **Appeal Process**

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

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

## **Appeals Determinations**

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

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

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

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

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

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

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

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

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

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

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

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

## **Legal Actions**

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

**Incontestability of Coverage**

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

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

**Information and Records**

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

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

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

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

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

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

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

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**Coordination of Benefits**

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

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

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

**Definitions**

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

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

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

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

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

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

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

**How Coordination Works**

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

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

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

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

**Which Plan Pays First**

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

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

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



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

- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - First, the plan of the parent with custody for the child.
  - Second, the plan of the spouse of the parent with the custody of the child.
  - Finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This rule does not apply with respect to any claim for which any benefits are actually paid or provided before the entity has that actual knowledge.
- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
- The benefits of a plan which covers a person as an employee who is neither laid off nor a Retiree are determined before those of a plan which covers that person as a laid off employee or a Retiree. The same rule applies if a person is a dependent of a person covered as a Retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

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

#### **Facility of Payment**

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

#### **Right of Recovery**

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

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

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### **Recovery Provisions**

#### **Refund of Overpayments**

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

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

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

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

### **Reimbursement of Benefits Paid**

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

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

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

### **Subrogation**

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

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

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

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## **Effect of Government Plans**

### **Government Plans (other than Medicare and Medicaid)**

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

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

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

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

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

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

[U.S. Behavioral Health Plan, California  
Attn: Grievances and Appeals  
P.O. Box 2839  
San Francisco, CA 94126]  
Phone number: 888-440-UCAL (8225)  
TDD line: 711]

Or at the USBHPC Web Site: [www.liveandworkwell.com](http://www.liveandworkwell.com)

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

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

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

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

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

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

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

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

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

#### **For Help**

Contact the DMHC Help Center at the toll-free telephone number **(1-888-466-2219)** to receive help with this process, or submit an inquiry in writing to the **DMHC Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725** or through the website:

**<http://www.dmhc.ca.gov>**. The hearing and speech impaired may use the California Relay Service's toll-free telephone number **1-800-735-2929 or 1-888-877-5378 (TTY)**.

#### **Appealing a Behavioral Health Benefit Decision**

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

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

### **Expedited Review Process**

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

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

### **Independent Medical Review of Grievances Involving a Disputed Behavioral Health Service**

A **Member** may request an Independent Medical Review (IMR) of disputed **Behavioral Health Services** from the Department of Managed Health Care if the **Member** believes that **Behavioral Health Services** have been improperly denied, modified or delayed by USBHPC. A “disputed Behavioral Health Service” is any **Behavioral Health Service**, requested by you or your provider, eligible for coverage that has been denied, modified or delayed, in whole or in part because the service is experimental or investigational or is not Medically Necessary. The IMR process is in addition to the procedures and remedies that are available to the **Member** under the Appeal Process described above. If the complaint or appeal pertains to a disputed **Behavioral Health Service** subject to IMR (as described below), the complaint or appeal should be filed within 180 days of receiving a denial notice.

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

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

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

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

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

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

If you have a Life-Threatening or Seriously Debilitating condition and your request for Experimental or Investigational therapy is denied, USBHPC will send a written notice of the denial within two business days of the decision. The notice will advise you of your right to request IMR, and include a Provider certification form and an application form with a preaddressed envelope to be used to request IMR. (Please note that you may request an IMR, if your request for Experimental or Investigational therapy is denied, without going through the USBHPC grievance process.)

### **Disputed Behavioral Health Services Regarding Medical Necessity**

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

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

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

## Accepted Applications for the Independent Medical Review

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

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

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

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

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

## The Independent Medical Review Decision

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

- In the case of a review of Experimental or Investigational determination, if the **Member's** Provider determines that the proposed treatment or therapy would be significantly less effective if not promptly initiated. In this instance, the analysis and recommendations will be rendered within seven days of the request for expedited review. The review period can be extended up to three days for a delay in providing required documents at the request of the expert.
- In the case of a review where the Behavioral Health Services has not been provided and the **Member's** Provider or the Department of Managed Health Care or CDI certifies in writing that an imminent and serious threat to the **Member's** may exist, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of the **Member's** health. In this instance, any analyses and

recommendation of the experts must be expedited and rendered within three days of the receipt of the **Member's** application and supporting information.

- If approved by the Department of Managed Health Care, the deadlines for the expert reviewers' analyses and recommendations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.
- The IRO will provide the Department of Managed Health Care, USBHPC, the **Member** and the **Member's** Provider with each of the experts' analyses and recommendations, and a description of the qualifications of each expert. The IRO will keep the names of the expert reviewers confidential, except in cases where the reviewer is called to testify and in response to court orders. In the case of an Experimental or Investigational determination, the experts' analyses will state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial to the **Member** than any available standard therapy and the reasons for recommending why the therapy should or should not be provided, citing the **Member's** specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the expert's recommendation.

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

#### **When an Independent Medical Review Decision is Made**

The Department of Managed Health Care will immediately adopt the decision of the IRO upon receipt and will promptly issue a written decision to the parties that will be binding on USBHPC. USBHPC will implement the decision when received from the Department of Managed Health Care within five (5) working days. In the case of services not yet rendered to the **Member**, USBHPC will authorize the services within five working days of receiving the written decision from the Department of Managed Health Care, or sooner if appropriate for the nature of the **Member's** medical condition and will inform the **Member** and the **Member's** Provider of the authorization.

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

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

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

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

#### **The Quality Review Process**

If a complaint is related to quality of care, the complaint will be reviewed under USBHPC's quality review process. The quality review process is a **Member** initiated internal review process that addresses **Member** concerns regarding the quality or appropriateness of services provided by a Participating Provider that has the potential for an adverse

effect on the **Member**. Upon receipt of the **Member's** concern, the concern is referred to the Quality Improvement Department for investigation. Quality of care complaints that affect a **Member's** current treatment will be immediately evaluated and if necessary, other appropriate USBHPC personnel and the Participating Provider will be consulted.

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

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

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

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



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## Glossary

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

### Advanced Practice Registered Nurse

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

### Behavioral Health Services

Services and supplies that are:

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

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

- Assessment
- Diagnosis
- Medication Management
- Individual, family and group psychotherapy and other psychotherapeutic methods
- Psychological testing
- Inpatient services, including **Hospital/Facility**-based treatment such as Acute Inpatient, Detoxification services, Residential Treatment, or Recovery Home treatment and any related Inpatient Professional Services
- Voluntary psychiatric inpatient services from licensed mental health providers including, but not limited to psychiatrists and psychologists
- Outpatient services, including treatment planning, biofeedback, intensive outpatient services, partial hospitalization/day treatment services, and methadone maintenance
- Behavioral health treatment for pervasive developmental disorders and autism
- Clinically Necessary treatment for all Severe Mental Illness of a person of any age or Serious Emotional Disturbance of a child.

- **Telehealth** - no face-to-face contact is required between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the Plan.
- Crisis intervention and stabilization

### **Calendar Year**

A period of one year beginning with January 1

### **Clinically Necessary**

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

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

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

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

- *Treating Practitioner* means a provider who has personally evaluated the patient. For these purposes, a “provider” includes but is not limited to one of the eligible behavioral health providers listed in the definition of Behavioral Health Services.
- A *health intervention* is Mental Health and Substance Abuse Treatment delivered or undertaken primarily to treat (that is, prevent, diagnosis, detect, treat or palliate) a behavioral health disorder, psychological injury, or substance abuse addiction, or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the condition and the patient indications for which it is being applied.
- *Effective* means that the intervention can reasonably be expected to produce the intended result and to have expected benefits that outweigh potential harmful effects.
- *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person’s life.
- *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the condition or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Clinically Necessary in the absence of

scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

- A *new intervention* is one that is not yet in widespread use for the condition and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.
- An intervention is considered *cost-effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. The application of this criterion is to be on an individual case and the characteristics of the individual patient shall be determinative.

### **Course of Treatment**

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

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

### **Covered Expenses**

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

### **Member**

- A **Member** is a properly enrolled Employee/Retiree and his/her properly enrolled Family Members. Further detail can be found in the “Complete Guide to Your UC Health and Welfare Benefits” and the “Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members”. Copies are available in the HR Forms section of UCnet (<https://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 “A Complete Guide to Your UC Health and Welfare Benefits”. A copy is available in the HR Forms section of UCnet ([ucnet.universityofcalifornia.edu](https://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 one or more Acute Inpatient, Detoxification services, Residential Treatment or Recovery Home treatment service, as appropriate, and is:

- Accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- Approved by **Medicare** as a hospital.
- Meets all of the following tests:
  - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians.
  - It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered graduate nurses.
  - It is operated continuously with organized facilities for operative surgery on the premises.
- Licensed by the California State Department of Health Services or it operates under a waiver of licensure granted by the California State Department of Mental Health.

### **Participating Provider (also referred to as USBHPC Network)**

A provider who participates in USBHPC's network.

### **Inpatient Treatment**

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

### **Licensed Counselor**

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

### **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/or substance abuse treatment for the following:

- Any sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) other than those shown in the **What's not Covered – Exclusions** section, including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause, and
- Any sickness where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.
- Specifically Covered Services shall include the diagnosis and **Medically Necessary** treatment of Severe Mental Illness, which shall include the following conditions:
  - Schizophrenia
  - Schizoaffective disorder
  - Bipolar disorder (manic- depressive illness)
  - Major depressive disorders
  - Panic disorder
  - Obsessive-compulsive disorder

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

All **Inpatient** services, including room and board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a sickness identified in the Diagnostic and Statistical Manual of Mental Disorders (other than those shown in the **What's not Covered – Exclusions** section), are considered **Mental Health and Substance Abuse Treatment**, except in the case of multiple diagnoses.

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

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

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

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

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

**Non-Participating Provider**

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

**Physician**

A legally qualified:

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

**Plan**

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

**Provider**

A person who is qualified and duly licensed, certified, or otherwise authorized pursuant to state law to furnish **Mental Health and Substance Abuse Treatment** independently without supervision, or where required by state law, under the supervision of an independently practicing provider who employs the person.

**Psychiatric Emergency Medical Condition**

A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as

being either of the following: a) an immediate danger to himself or herself or to others; b) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

### **Psychologist**

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

- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

### **Recovery Home**

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

### **Residential Treatment**

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

### **Qualified Autism Service Provider**

Either of the following:

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

### **Qualified Autism Service Professional**

An individual who meets all of the following criteria:

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

### **Qualified Autism Service Paraprofessional**

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

- Is supervised by a **Qualified Autism Service Provider** or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the **Qualified Autism Service Provider**

- Meets the education and training qualifications described in Section 54342 of title 17 of the California Code of Regulations.
- Has adequate education, training, and experience, as certified by a Participating **Qualified Autism Service Provider** or entity or group that employs Qualified Autism Service Providers.
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

### **Reasonable Charge**

As to charges for services rendered by or on behalf of a Participating **Provider** amount not to exceed the amount determined by the Company in accordance with the applicable fee schedule.

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

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

### **Registered Mental Health Psychiatric Nurse**

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

### **Registered Nurse**

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

### **Retiree**

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

### **Retrospective Review**

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

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

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

### **Social Worker**

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

### **Substance Abuse Rehabilitation**

Treatment for a substance abuse disorder in a twenty-four (24) hour setting, or other setting outside of an acute care **Hospital** that is licensed to perform that service and where there is no danger of medical complications due to detoxification.

### **Telehealth**

The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and

education using interactive audio, video, or data communications rather than in-person with the provider that is over a secured connection as required by applicable policies and federal and state law (including HIPAA).

### **Telephonic Counseling**

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

### **Treatment Center**

A facility which provides a program of effective **Mental Health and Substance Abuse Treatment** and meets all of the following requirements:

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

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

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

### **Utilization Review**

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

**End of Evidence of Coverage**



## **Attachment – A**

### **Other Disclosures & Department of Managed Health Care Information**

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

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

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

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

**CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (DMHC):**

**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.dmhc.ca.gov/>

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

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

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

**English**

**IMPORTANT LANGUAGE INFORMATION:**

You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. If you need more help, call HMO Help Line at 1-888-466-2219.

**Spanish**

**INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:**

Es probable que usted disponga de los derechos y servicios a continuación. Puede pedir un intérprete o servicios de traducción sin cargo. Es posible que tenga disponible documentación impresa en algunos idiomas sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud de U.S. Behavioral Health Plan, California al 1-800-999-9585 / TTY: 711. Si necesita más ayuda, llame a la línea de ayuda de la HMO al 1-888-466-2219.

**Chinese**

**重要語言資訊：**

您可能有資格享有下列權利並取得下列服務。您可以免費獲取口譯員或翻譯服務。部分語言亦備有免費書面資訊。如需取得您語言的協助，請撥打下列電話與您的健保計畫聯絡：U.S. Behavioral Health Plan，California 1-800-999-9585 / 聽力語言殘障服務專線 (TTY)：711。若您需要更多協助，請撥打 HMO 協助專線 1-888-466-2219。

**Arabic**

**معلومات مهمة عن اللغة:**

ربما تكون مؤهلاً للحصول على الحقوق والخدمات أدناه. فيمكنك الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. وربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. وللحصول على مساعدة بلغتك، يُرجى الاتصال بخطتك الصحية على: U.S. Behavioral Health Plan, California على الرقم 1-800-999-9585 / وإذا احتجت لمزيد من المساعدة، يمكنك الاتصال بخط المساعدة التابع لـ HMO على الرقم 1-888-466-2219.

**Armenian**

**ԿԱՐԵՎՈՐ ԼԵԶՎԱԿԱՆ ՏԵՂԵԿՈՒԹՅՈՒՆ՝**

Հավանաբար է, որ Ձեզ հասանելի լինեն հետևյալ իրավունքներն ու ծառայությունները: Կարող եք ստանալ բանավոր թարգմանչի կամ թարգմանության անվճար ծառայություններ: Հնարավոր է, որ մի շարք լեզուներով նաև առկա լինի անվճար գրավոր տեղեկություն: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել Ձեր առողջապահական ծրագիր՝ U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY՝ 711 համարով: Հավելյալ օգնության կարիքի դեպքում, զանգահարեք HMO-ի Օգնության հեռախոսագիծ 1-888-466-2219 համարով:

**Cambodian**

**ព័ត៌មានសំខាន់អំពីភាសា៖**

អ្នកអាចនឹងមានសិទ្ធិ ចំពោះសិទ្ធិ និងសេវានៅខាងក្រោម។ អ្នកអាចទទួលអ្នកបកប្រែ ឬសេវាការបកប្រែ ដោយឥតគិតថ្លៃ។ ព័ត៌មានដែលបានសរសេរ ក៏អាចនឹងមានជាភាសាមួយចំនួន ដោយឥតគិតថ្លៃដែរ។ ដើម្បីទទួលបានជំនួយជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅគំរោងសុខភាពរបស់អ្នក នៅ៖ U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711។ បើសិនអ្នកត្រូវការជំនួយថែមទៀត ហៅខ្សែទូរស័ព្ទជំនួយ HMO តាមលេខ 1-888-466-2219។

## Farsi

### اطلاعات مهم در مورد زبان:

شما ممکن است برای حقوق و خدمات زیر واجد شرایط باشید. می توانید خدمات مترجم شفاهی یا ترجمه را بدون پرداخت هزینه دریافت کنید. اطلاعات کتبی نیز ممکن است بدون پرداخت هزینه به برخی زبان ها موجود باشد. برای دریافت کمک و راهنمایی به زبان خودتان، لطفاً با برنامه درمانی: U.S. Behavioral Health Plan, California به شماره 1-800-999-9585/ TTY: 711 تماس بگیرید. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط دریافت کمک و راهنمایی HMO به شماره 1-888-466-2219 تماس بگیرید.

## Hindi

### भाषा-संबंधी महत्वपूर्ण जानकारी:

आप निम्नलिखित अधिकारों और सेवाओं के हकदार हो सकते हैं। आपको मुफ्त में दुभाषिया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में लिखित जानकारी भी आपको मुफ्त में उपलब्ध कराई जा सकती है। अपनी भाषा में सहायता प्राप्त करने के लिए, कृपया अपने स्वास्थ्य प्लान को यहाँ कॉल करें: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711। पर। अतिरिक्त सहायता की आवश्यकता पड़ने पर, HMO Help Line को 1-888-466-2219 पर कॉल करें।

## Hmong

### COV NTAUB NTAUV LUS TSEEM CEEB:

Tej zaum koj yuav muaj cai rau cov cai pab cuam hauv qab no. Koj tuaj yeem tau txais ib tug kws txhais lus los sis txhais ntawv pub dawb. Cov ntaub ntawv sau no muaj sau ua qee yam ntaub ntawv pub dawb rau sawd daws. Yuav tau txais kev cov ntaub ntawv sau ua koj lus, thov hu rau qhov chaw npaj kho mob rau ntawm: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. Yog koj xav tau kev pab ntxiv, hu rau HMO Help Line ntawm tus xov tooj 1-888-466-2219.

## Japanese

### 言語支援サービスについての重要なお知らせ :

お客様には、以下のような権利があり、必要なサービスをご利用いただけます。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された情報を無料でご利用できる場合もあります。ご希望の言語による援助をご希望の方は、お客様の医療保険プランにご連絡ください : U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711。この他のサポートが必要な場合には、HMO Help Line に 1-888-466-2219 にてお問い合わせください。

## Korean

### 중요 언어 정보:

귀하는 아래와 같은 권리 및 서비스를 누리실 수 있습니다. 귀하는 통역 혹은 번역 서비스를 비용 부담없이 이용하실 수 있습니다. 일부 언어의 경우 서면 번역 서비스 또한 비용 부담없이 제공될 수도 있습니다. 귀하의 언어 지원 서비스가 필요하시면 귀하의 건강보험에 다음 전화번호로 문의하십시오. U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. 더 많은 도움이 필요하신 분은 HMO 헬프 라인(안내번호: 1-888-466-2219)으로 문의하십시오.

## **Punjabi**

### **ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਦੀ ਜਾਣਕਾਰੀ:**

ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵਿੱਚ ਬਿਨਾਂ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮਿਲ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ HMO ਹੈਲਪ ਲਾਈਨ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-466-2219।

## **Russian**

### **ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:**

Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на вашем языке, пожалуйста, позвоните по номеру вашего плана: U.S. Behavioral Health Plan, California 1-800-999-9585 / линия TTY: 711. Если вам все еще требуется помощь, позвоните в службу поддержки HMO по телефону 1-888-466-2219.

## **Tagalog**

### **MAHALAGANG IMPORMASYON SA WIKA:**

Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng interpreter o mga serbisyo sa pagsasalín nang walang bayad. Maaaring may available ding libreng nakasulat na impormasyon sa ilang wika. Upang makatanggap ng tulong sa iyong wika, mangyaring tumawag sa iyong planong pangkalusugan sa: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. Kung kailangan mo ng higit pang tulong, tumawag sa HMO Help Line sa 1-888-466-2219.

## **Thai**

### **ข้อมูลสำคัญเกี่ยวกับภาษา :**

คุณอาจมีสิทธิได้รับสิทธิและบริการต่าง ๆ ด้านล่างนี้ คุณสามารถขอลาแปลภาษาหรือบริการแปลภาษาได้ โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ ยังอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ โปรดโทรศัพท์ถึงแผนสุขภาพของคุณที่ : U.S. Behavioral Health Plan, California 1-800-999-9585 / สำหรับผู้มีความบกพร่องทางการฟัง : 711 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ให้ความช่วยเหลือเกี่ยวกับ HMO ที่หมายเลขโทรศัพท์ 1-888-466-2219

## **Vietnamese**

### **THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:**

Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu được cung cấp một thông dịch viên hoặc các dịch vụ dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể sẵn có ở một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị tại: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. Nếu quý vị cần trợ giúp thêm, xin gọi Đường dây hỗ trợ HMO theo số 1-888-466-2219.