UNIVERSITY OF CALIFORNIA

Behavioral Health Benefits for
Anthem Blue Cross PPO Members

January 1, 2012

Insured by

Unimerica Insurance Company

(called the "Company")

Administered by:

Important notice about this Certificate of Coverage

ATTENTION MEMBERS WHO ARE PERMANENT RESIDENTS OF:

ARKANSAS, KANSAS, LOUISIANA*, MASSACHUSETTS, MISSOURI, MONTANA, NEW HAMPSHIRE, OKLAHOMA, PENNSYLVANIA, SOUTH CAROLINA, AND TEXAS

Please see the Schedules of Benefits at the end of the booklet for coverage details.
For further information please call 1-888-440-UCAL (8225).

*For members who are permanent residents of Louisiana, please see the additional Important Notice at the end of the booklet.

Table of Contents

Certification

INSURANCE BOOKLET

for Employees and Retirees of the

UNIVERSITY OF CALIFORNIA

and its Affiliates (and their Eligible Family Members)

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

insured by

UNIMERICA INSURANCE COMPANY
Milwaukee, Wisconsin
(called the Company)

CERTIFICATE OF INSURANCE

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

The policy provides behavioral health benefits.

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

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

This Certificate describes the Plan in effect as of January 1, 2012.

This Certificate replaces any and all Certificates previously issued for Employee/Retirees under the plan.

UNIMERICA INSURANCE COMPANY

John M. Prince
President

The behavioral health benefits described in this Plan are administered by United Behavioral Health ("UBH").

1-888-440-UCAL (8225)

Schedule of Benefits

Effective Date of this Plan **January 1, 2012**

Behavioral Health Benefits for Anthem Blue Cross PPO Members

Covered Services	**In-Network[1] Providers** **Member Cost Sharing**	**Out-of-Network[2] Providers** **Member Cost Sharing**
Calendar Year Deductible[3]		
Individual	N/A	$500
Family	N/A	$1,500
Annual Out-of-Pocket Maximums (includes deductibles)[4]		
Individual	$3,000	$6,000
Family	$9,000	$18,000
Lifetime Maximum	N/A	N/A
Outpatient (Counseling visits, Structured/Intensive Outpatient care, etc.)	Visits 1-3: No Cost Visits 4+: 20% No cost for children through age 6	40% after deductible
Inpatient (Facility-based treatment such as Acute care, Residential treatment, Partial hospitalization, etc.)	20%	40% after deductible[5]
Penalty for Failure to Preauthorize		
Inpatient Treatment[6, 7]	$200	$200

1. To be covered at the In-Network benefit level, services must be Clinically Necessary and provided by a UBH In-Network clinician. Covered Services include outpatient counseling and preauthorized inpatient services (see "Preauthorization Requirement and Utilization Review" section for further information). If inpatient services are not preauthorized, they will be covered after a $200 penalty if it is determined they were Clinically Necessary. The Preauthorization Requirement does not apply to Emergency services.
2. To be covered at the Out-of-Network benefit level, services must be Clinically Necessary, which will be determined through Retrospective Review. Expenses determined not Clinically Necessary will not be covered. Covered Services include outpatient counseling and preauthorized inpatient services (see "Preauthorization Requirement and Utilization Review" section for further information). If inpatient services are not preauthorized, they will be covered after a $200 penalty if it is determined they were Clinically Necessary. The Preauthorization Requirement does not apply to Emergency Services. Out-of-Network member Cost Sharing is 40% of "allowed" charges. "Allowed" Charges are based on the lesser of Reasonable & Customary or billed charges. Charges in excess of "allowed" charges are not covered.
3. Non-Medicare members may use covered Out-of Network Mental Health, Substance Abuse, and Medical expenses to satisfy the Out-of-Network Deductible. Medicare members may use covered Out-of-Network Mental Health and Substance Abuse expenses to satisfy the Out-of-Network Deductible.
4. In-Network and Out-of-Network Out-of-Pocket Maximums are exclusive of each other. Non-Medicare members may use covered In-Network Mental Health, Substance Abuse and Medical expenses to satisfy the In-Network Out-of-Pocket Maximums. Non-Medicare members may use covered Out-of-Network Mental Health, Substance Abuse, and Medical expenses to satisfy the Out-of-Network Out-of-Pocket Maximum. Medicare members may use covered In-Network Mental Health and Substance Abuse expenses to satisfy the In-Network Out-of-Pocket Maximums. Medicare members may use covered Out-of-Network Mental Health and Substance Abuse expenses to satisfy the Out-of-Network Out-of-Pocket Maximum. In addition, for Medicare members, Member In-Network Out-of-Pocket expenses for treatment of conditions defined under California law AB88 as "Severe Mental Illness" will also apply to the In-Network Out-of-Pocket maximum in

the member's medical plan. Once the members' medical plan In-Network Out-of-Pocket maximum is met, the member will have no further behavioral health Out-of-Pocket expenses for In-Network treatment of conditions defined as "Severe Mental Illness."

5. Emergency care rendered by an Out-of-Network provider will be paid at the In-Network benefit level. Emergency care is defined as "Immediate Treatment when the lack of treatment could reasonably be expected to result in the patient harming him/herself or another person(s)."
6. The Penalty for Failure to Preauthorize Treatment applies to Inpatient In-Network and Out-of-Network services and is applied per admission/course of treatment. This Penalty is applied before the Covered Person accumulates covered expenses toward the individual Deductible and the Penalty does not apply toward the individual Deductible. If the individual Deductible is satisfied, the Penalty is applied prior to the Plan's percentage payment.
7. The Penalty for Failure to Preauthorize Treatment applies when the plan is not notified in advance of the member receiving non-emergency services.

Notes

- Members permanently residing outside California should check the pages following the Certificate of Insurance for special State provisions that may affect the benefits shown in this summary.
- Mental health/substance abuse claims with out-of-network providers should be submitted online at ***www.liveandworkwell.com****;* if that is not possible, claims can be submitted on paper to:
  United Behavioral Health, P.O. Box 30760, Salt Lake City, UT 84130-0760.

Eligibility, Enrollment and Termination Provisions

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

ELIGIBILITY

The following individuals are eligible to enroll in this Plan. If the Plan is a Point of Service (POS) Plan, they are only eligible to enroll in the Plan if they meet the Plan's geographic service area criteria as residents of California. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan (not applicable to members of the Anthem Blue Cross PPO Medicare without Prescription Drug Plan).

Subscriber

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

* Lecturers - see your benefits office for eligibility.

****** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree: A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit Plan provided that you also meet the following requirements:

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

A **Survivor**—a deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the UC *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members* or the *Survivor and Beneficiary Handbook*.

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree Enrollment" below.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members, including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), domestic partner verification,

adoption records, court documentation confirming a child's status as a legal ward, Federal Income Tax Return, or other official documentation.

Eligible Adult: You may enroll one eligible adult Family Member, in addition to yourself:

Spouse: Your legal spouse.

Domestic Partner:

You may enroll your same-sex domestic partner if your partnership is registered with the State of California or otherwise meets criteria as a domestic partnership as set forth in the University of California Group Insurance Regulations. Same-sex domestic partners from jurisdictions other than California will be covered to the extent required by law. You may enroll your opposite-sex domestic partner only if either you or your domestic partner is age 62 or older and eligible to receive Social Security benefits based on age. Your domestic partner (same-sex or opposite sex) must be at least 18 years of age.

Note: An adult dependent relative is not eligible for coverage in UC plans (unless enrolled prior to December 31, 2003 and continuously eligible and enrolled since that date (e.g., continues to be ineligible for Medicare PartA)).

Child: All eligible children must be under the limiting age of 26 (18 for legal wards) except for a child who is incapable of self-support due to a physical or mentally disabling injury, illness or condition. The following categories are eligible:

(a) your natural or legally adopted children;
(b) your spouse's natural or legally adopted children (your stepchildren);
(c) your eligible domestic partner's natural or legally adopted children;
(d) grandchildren of you, your spouse or your eligible domestic partner if unmarried, living with you, dependent on you, your spouse or your eligible domestic partner for at least 50% of their support and are your, your spouse's, or your eligible domestic partner's dependents for income tax purposes;
(e) children for whom you are the legal guardian if unmarried, living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.
(f) children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet UC eligibility requirements.)

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 26 provided:

- the plan-certified disability began before age 26, the child was enrolled in a UC group medical plan before age 26 and coverage is continuous;
- the child is chiefly dependent upon you. your spouse, or your eligible domestic partner for support and maintenance (50% or more); and
- the child is claimed as your, your spouse's or your eligible domestic partner's dependent for income tax purposes, or if not claimed as such dependent for income tax purposes, is eligible for Social Security Income or Supplemental Security Income as a disabled person, or working in supported employment which may offset the Social Security or Supplemental Security Income.

Application for coverage beyond age 26 due to disability must be made to the Plan sixty days prior to the date coverage is to end due to reaching limiting age. If application is received timely but Plan does not complete determination of the child's continuing eligibility by the date the child reaches the Plan's upper age limit, the child will remain covered pending Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Disabled children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required; however, the new Plan may require proof of continued disability, but not more than once a year.

If you are a newly hired Employee with a disabled child over age 26 or if you newly acquire a disabled child over age 26 (through marriage, adoption or domestic partnership), you may also apply for coverage for that child. The child's disability must have begun prior to the child turning age 26. Additionally, the child must

have had continuous group medical coverage since age 26, and you must apply for University coverage during your Period of Initial Eligibility. The Plan will ask for proof of continued disability, but not more than once a year after the initial certification.

Important Note: The University complies with federal and state law in administering its group insurance programs. Health and welfare benefits and eligibility requirements, including dependent eligibility requirements are subject to change (e.g., for compliance with applicable laws and regulations). The University also complies with federal and state income tax laws which are subject to change. Requirements may include laws mandating that the employer contribution for coverage provided to certain Family Members be treated as imputed income to the Employee. See At Your Service online for related information. Contact your tax advisor for additional information.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may enroll and cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's (UC) Customer Service Center at (800) 888-8267. You may also access eligibility factsheets on UC's *At Your Service* web site: http://atyourservice.ucop.edu.

ENROLLMENT

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

During a Period of Initial Eligibility (PIE)

A PIE begins the day you become eligible and ends 31 days after it began (but see exception under "Special Circumstances" paragraph 1.d below). Also see "At Other Times for Employees and Retirees" below. If the last day of a PIE falls on a weekend or holiday, the PIE is extended to the following business day if you are enrolling with paper forms.

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

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

(a) For a spouse, on the date of marriage.

(b) For a Domestic Partner, on the date the domestic partnership is legally established. Also see "At Other Times for Employees and Retirees" below.

(c) For a natural child, on the child's date of birth.

(d) For an adopted child, the earlier of:
  (i) the date the child is placed for adoption with the Employee/Retiree, or
  (ii) the date the Employee/Retiree or Spouse/Domestic Partner has the legal right to control the child's health care.

A child is "placed for adoption" with the Employee/Retiree as of the date the Employee/Retiree assumes and retains a legal obligation for the child's total or partial support in anticipation of the child's adoption.

If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

(e) For a legal ward, the effective date of the legal guardianship.

(f) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you are in a Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), or Point of Service (POS) Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan available in the new location. Your PIE starts with the effective date of the move or the date you leave the Plan's service area. Upon return to the service area, you will have a PIE to reenroll yourself and eligible Family Members in the same HMO, EPO or POS you had at the time of the move out of the area. The PIE begins with the effective date of the return to the service area.

At Other Times for Employees and Retirees

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

90-Day Waiting Period. If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period unless one of the "Special Circumstances" described below applies.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period unless one of the "Special Circumstances" described below applies.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

Newly Eligible Child. If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

Special Circumstances. You may enroll before the end of the 90-day waiting period or without waiting for the University's next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:

   a. You were covered under another health plan as an individual or dependent, including coverage under COBRA or CalCOBRA (or similar program in another state), the Children's Health Insurance Program or "CHIP" (called the Healthy Families Program in California), or Medicaid (called Medi-Cal in California).

   b. You stated at the time you became eligible for coverage under this Plan that you were declining coverage under this Plan or disenrolling because you were covered under another health plan as stated above.

   c. Coverage under another health plan for you and/or your eligible Family Members ended because you/they lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, coverage under COBRA or CalCOBRA continuation was exhausted, or coverage under CHIP or Medicaid was lost because you/they were no longer eligible for those programs.

   d. You properly file an application with the University during the PIE which starts on the day after the other coverage ends. **Note that if you lose coverage under CHIP or Medicaid, your PIE is 60 days.**

2. You or your eligible Family Members are not currently enrolled in UC-sponsored medical coverage and you or your eligible Family Members become eligible for premium assistance under the Medi-Cal Health Insurance Premium Payment (HIPP) Program or a Medicaid or CHIP premium assistance program in another state. Your PIE is 60 days from the date you are determined eligible for premium assistance. If the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following business day if you are enrolling with paper forms.

3. A court has ordered coverage be provided for a dependent child under your UC-sponsored medical plan pursuant to applicable law and an application is filed within the PIE which begins the date the court order is issued. The child must also meet UC eligibility requirements.

4. You have a change in family status through marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:

    a. If you are enrolling following marriage or establishment of a domestic partnership, you and your new spouse or domestic partner must enroll during the PIE. Your new spouse or domestic partner's eligible children may also enroll at that time. Coverage will be effective as of the date of marriage or domestic partnership provided you enroll during the PIE.

    b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse or domestic partner, who is eligible but not enrolled, may also enroll at that time. Application must be made during the PIE; coverage will be effective as of the date of birth, adoption, or placement for adoption provided you enroll during the PIE.

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring, and you may change your plan during the University's next open enrollment period. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin). Retirement alone does not grant a PIE to enroll or change your medical plan. If you are a Survivor, you may not enroll your legal spouse or domestic partner.

Effective Date

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

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

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

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

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

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

(a) the date the Child becomes eligible, or
(b) a maximum of 60 days prior to the date your Child's enrollment form is received by your local Benefits or Payroll Office.

Change in Coverage

In order to make any of the changes described above, contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

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

Retirees or their Family Member(s) who become eligible for premium-free Medicare Part A on or after January 1, 2004 and do not enroll in and continue Part B will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium-free Medicare Part A between July 1, 1991 and January 1, 2004, but declined to enroll in Part B of Medicare, are assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B.

Retirees or Family Members who are not eligible for premium-free Part A will not be required to enroll in Part B, they will not be assessed an offset fee, nor will they lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium-free Medicare Part A will not be required to enroll in Part B.)

An exception to the above rules applies to Retirees or Family Members in the following categories who will be eligible for the non-Medicare premium applicable to this plan and will also be eligible for the benefits of this plan without regard to Medicare:

a) Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.
b) Individuals who are not eligible for premium-free Part A.

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

Upon Medicare eligibility, you or your Family Member must complete a University of California *Medicare Declaration* form, as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's *Medicare Declaration* form is available through the UC Customer Service Center or from the web site: http://atyourservice.ucop.edu. Completed forms should be returned to University of California, Human Resources, Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-1570.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care contract must assign his/her Medicare benefit (including Part D) to that plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Advantage Managed Care contract will be deenrolled from this health plan. Any individual enrolled in a University-sponsored Medicare Part D Prescription Drug Plan must assign his/her Part D benefit to the plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan (not applicable to members of the Anthem Blue Cross PPO Medicare Without Prescription Drug Plan).

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. Employees or their spouses, age 65 or over, and UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For those eligible for a group health plan due to employment, MSP indicates that Medicare becomes the secondary payer and the employer plan becomes the primary payer. You and your spouse should carefully consider the impact on your health benefits and premiums at age 65 or should you decide to return to work after you retire.

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

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

Some physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in

effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see **other** providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

TERMINATION OF COVERAGE

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

Deenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month for which premiums are taken from earnings based on an eligible appointment. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those services yourself. You may be entitled to continued benefits under terms which are specified in your medical plan booklet. (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under this Plan.)

If you are a Retiree or Survivor and your monthly retirement payments covered by a University-sponsored defined benefit plan terminate, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for the retirement income.

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

Deenrollment Due to Fraud or Intentional Misrepresentation

Coverage for you and/or your Family Members may be suspended for up to 12 months if you or a Family Member commit fraud or make an intentional misrepresentation of material fact relating to Plan coverage. Individuals who are enrolled, but who are not eligible Family Members will be permanently deenrolled.

Leave of Absence, Layoff, Change in Employment Status or Retirement

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

Optional Continuation of Coverage

As a participant in this plan you may be entitled to continue health care coverage for yourself, spouse or family members if there is a loss of coverage under the plan as a result of a qualifying event under the terms of the federal COBRA continuation requirements under the Public Health Service Act, as amended, and, if that continued coverage ends, you may be eligible for further continuation under California law. You or your family members will have to pay for such coverage. You may direct questions about these provisions to CONEXIS, UC's COBRA administrator or visit the website http://atyourservice.ucop.edu/employees/health_welfare/cobra.html

Contract Termination

Coverage under the Plan is terminated when the group contract between the University and the Plan Vendor is terminated. Benefits will cease to be provided as specified in the contract and you may have to pay for the cost of those benefits yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under this Plan.)

Behavioral Health Benefits

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

What This Plan Pays

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

The best way to ensure services will be covered is to call UBH at 1-888-440-UCAL (8225) in advance for preauthorization. Calling UBH will assure referral to the most appropriate treatment.

There is an instance where failure to preauthorize treatment will result in a penalty. Expenses for **Inpatient** treatment that was not preauthorized will result in a $200 penalty per admission/**Course of Treatment**.

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

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

Each **Covered Person** must satisfy certain copayments and/or deductibles 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.

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

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

Behavioral Health Services are services and supplies which are:

- **Covered Services** for Mental **Health and Substance Abuse Treatment.**
- Given while the **Covered Person** is covered under this Plan.
- Rendered by one of the following **Providers**:
  - Physician
  - Psychologist
  - Licensed Counselor
  - Hospital
  - Treatment Center
  - Social Worker

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

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

- **Telemedicine**. 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. (This is not the same as **Telephonic Counseling** which is not covered under this plan.)

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

Preauthorization Requirement and Utilization Review
A penalty applies to **Covered Expenses** if the **Covered Person** does not call UBH for authorization of treatment before obtaining **Inpatient Mental Health and Substance Abuse Services (the Preauthorization Requirement)**. In order to avoid the penalties, the **Covered Person** must call United Behavioral Health (UBH) before Behavioral Health expenses are incurred. This applies even if the treatment is with a **UBH Provider.** The toll-free number is 1-888-440-UCAL (8225) and the phone is answered 7 days-a-week, 24 hours-a-day. This call starts the **Utilization Review** process in which the Intake Counselor will assist the **Covered Person** in identifying his/her needs, then refer the **Covered Person** to **In-Network Providers** who are experienced in addressing his/her specific issues.

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

- **Inpatient** Benefits are subject to a preauthorization requirement. If this treatment is not preauthorized, a $200.00 Penalty will be applied. The amount of the Penalty will never be more than the **Covered Expense**.

- Benefits are subject to **Retrospective Review** at the time a claim is submitted for payment in order to determine if the services incurred are **Medically Necessary Covered Services**.

If the **Covered Person** is not able to locate an **In-Network Provider**, or is not satisfied with an **In-Network Provider**, he/she may call UBH and ask for a referral to another **In-Network Provider**.

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

This applies other than in the case of **Emergency Care**. Please see the following section for information pertaining to **Emergency Care.**

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

When **Emergency Care** is required for Mental **Health and Substance Abuse Treatment,** the **Covered Person** (or his/her representative or his/her **Provider**) must call UBH within forty-eight (48) hours after the **Emergency Care** is given. If it is not reasonably possible to make this call within forty-eight (48) hours, the call must be made as soon as reasonably possible. The Company will pay for **Emergency Care** services regardless of the **Provider's** contract status with the Company, and the plan will reimburse these **Covered Expenses** at the **In-Network** benefit level.

When the **Emergency Care** has ended, the **Covered Person** must get a referral from UBH before any additional services will be covered at the **In-Network** level. If the Covered Person does not get a referral as required, benefits for any additional services are payable at the **Out-of-Network** level.

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

Copayments and Deductibles
Before behavioral health benefits are payable, each **Covered Person** must satisfy certain Copayments and/or Deductibles. The amount of each Copayment/Deductible is shown in the **Schedule of Benefits**. A **Covered Expense** can only be used to satisfy one **Copayment** or **Deductible**.

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

A **Deductible** is the amount of Out-of-Network **Covered Expenses** the **Covered Person** must pay each **Calendar Year** before **Out-of-Network** behavioral health benefits are payable. Non-Medicare members may use covered **Out-of-Network** mental health, substance abuse, and medical expenses to satisfy the **Out-of-Network Calendar Year** Deductible. Medicare members

may use covered **Out-of-Network** mental health and substance abuse expenses to satisfy the **Out-of-Network Calendar Year** Deductible. After the Deductible has been met, Covered mental health and substance abuse expenses are payable at the percentages shown in the **Schedule of Benefits**.

Out-of-Pocket Feature
As shown in the **Schedule of Benefits**, certain **Covered Expenses** are subject to the applicable **Calendar Year** Deductible and Copayments until the Out-of-Pocket Maximum has been reached during a **Calendar Year**. The Out-of-Pocket Maximums for **In-Network** and **Out-of-Network Covered Expenses** are separate.

For Non-Medicare members, the annual Out-of-Pocket maximum for these benefits and the medical benefits is one and the same. The Out-of-Pocket Maximum may be met with covered mental health, substance abuse, and medical expenses. 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**. For Medicare members, the annual Out-of-Pocket maximum for these benefits may be met with covered mental health and/or substance abuse expenses. Once the member's combined mental health and substance abuse expenses meet the Out-of-Pocket maximum, the member will have no further Out-of-Pocket expenses for covered mental health or substance abuse services for the rest of that **Calendar Year**.

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

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

Out-of-Network
This Plan covers treatment and services received from **Out-of-Network Clinicians and Providers** as long as the **Provider** is qualified (see **What this Plan Pays**), treatment and services are **Covered Services,** and they meet **Medical Necessity** guidelines. If there are any questions, either the member or the **Out-of-Network Clinician** should speak with a UBH Intake Counselor or Care Advocate prior to commencing treatment. If the treatment is not a **Covered Service** and/or does not meet **Medical Necessity** guidelines, it will not be covered by this Plan.

What's Not Covered - Exclusions
The following exclusions apply regardless whether the services, supplies, or treatment described in this section are recommended or prescribed by the **Covered Person's Provider** and/or are the only available treatment options for the **Covered Person's** condition.

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

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM).
- Treatment or services which are medical in nature and covered under a medical plan.
- Prescription drugs or over-the-counter drugs and treatments. (Refer to your medical plan to determine whether prescription drugs are a covered benefit.)
- Services or supplies for Mental Health and Substance Abuse Treatment that, in the reasonable judgment of UBH 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 UBH's Level of Care Guidelines or best practices as modified from time to time. UBH may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.

- Treatment or services, except for the initial diagnoses, for a primary diagnoses of Mental Retardation (317, 318, 319), Learning, Motor Skills, and Communication Disorders (315), Conduct Disorder (312), Dementia (290, 294), Sexual and Paraphilia Disorders other than Sexual Identity Disorder (302), and Personality Disorders (301), 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 UBH.

- Unproven, Investigational or Experimental Services. 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.

- Custodial Care except for the acute stabilization of the **Covered Person** and returning the **Covered Person** back to his or her baseline levels of individual functioning. Care is determined to be custodial when:
  - it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the **Covered Person's** competent functioning in activities of daily living; or
  - it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the **Covered Person** to function outside a structured environment. This applies to **Covered Persons** for whom there is little expectation of improvement in spite of any and all treatment attempts.

- **Covered Persons** whose repeated and volitional non-compliance with treatment recommendations result in a situation in which there can be no reasonable expectation of a successful outcome.

- Neuropsychological testing when used for the diagnosis of attention deficit disorder.

- Examinations or treatment, unless it otherwise qualifies as **Behavioral Health Services**, when:
  - required solely for purposes of career, education, sports or camp, travel, employment, insurance or adoption;
  - ordered by a court except as required by law;
  - conducted for purposes of medical research; or
  - required to obtain or maintain a license of any type.

- Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

- Nutritional Counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.

- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.

- Services or treatment rendered by unlicensed **Providers**, including pastoral counselors (except as required by law), or which are outside the scope of the **Providers**' licensure.

- 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 UBH has requested and arranged for **Covered Person** to be transferred by ambulance from one facility to another.
- Services performed by a **Provider** who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the **Provider** may perform on himself or herself.
- Services performed by a **Provider** with the same legal residence as the **Covered Person**.
- **Behavioral Health Services** for which the **Covered Person** has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the **Plan**.
- Charges in excess of any specified **Plan** limitations.
- Any charges for missed appointments.
- Any charges for record processing except as required by law.
- Services Provided Under Another Plan. Services or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes but is not limited to coverage required by workers' compensation, no-fault auto, or similar legislation. If coverage under workers' compensation or a similar law is optional for **Covered Person** because **Covered Person** could elect it or could have it elected for him or her, benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected.
- **Behavioral Health Services** received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country when **Covered Person** is legally entitled to other coverage.
- Treatment or services received prior to **Covered Person** being eligible for coverage under the **Plan** or after the date the **Covered Person's** coverage under the **Plan** ends.
- **Telephonic counseling**, therapy performed over the telephone with a Covered Person by a mental health or substance abuse professional.

In-Network Provider Charges Not Covered

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

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

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

Claims Information

How to File a Claim

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

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

If filing claims electronically is not possible, following are the steps to submit bills for payment for services and supplies received from **Out-of- Network Providers**:

You may get a claim form in one of two ways. **Either** go online to www.liveandworkwell.com enter access code 11280 and download the form (note the address where to send the claim is at the top of the form and there are instructions "How to file a claim" on that site), **or** call UBH at 1-888-440-UCAL (8225) and request a form be sent to you. If you request a claim form but do not receive it within 15 days, you can file a claim without it by sending the bills with a letter, including all of the information listed below.

Once you have the claim form, complete the Employee/Retiree portion of the form, ask the **Out-of-Network Provider** to complete the **Provider** portion of the form, and send the completed form and bills to:

United Behavioral Health
P. O. Box 30760
Salt Lake City, UT 84130-0760

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

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

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

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

.

The claim/billing statement should be mailed to:

United Behavioral Health
P.O. Box 30760
Salt Lake City, UT 84130-0760

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

When Claims Must be Filed

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

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

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

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

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

UBH will make a benefit determination as set forth below. Benefits will be paid to the covered Employee/Retiree as soon as UBH 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, UBH will make payments directly to the **Provider** of care.
- If UBH pays benefits directly to **In-Network Providers**.
- If the covered Employee/Retiree requests in writing that payments be made directly to a **Provider**. A covered Employee/Retiree does this when completing the claim form.

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

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

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

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

Benefit Determinations

Pre-Service Claims

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

Concurrent Care Claims

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

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

Post-service Claims

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

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

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

Urgent Claims that Require Immediate Attention

Urgent claims are those **Emergency Care** claims that require authorization or a benefit determination prior to receiving **Mental Health and Substance Abuse Services**. In these situations:

- The **Covered Person** will receive notice of the benefit determination within 24 hours after UBH receives all necessary information, taking into account the seriousness of the **Covered Person's** condition, with written or electronic notification 72 hours after.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

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

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

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

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

Questions or Concerns about Benefit Determinations

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

A **Covered Person** has the right to appeal a rescission of coverage determination.

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

How to Appeal a Claim Decision

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

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

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

The Appeal should be submitted to the following address:

United Behavioral Health
Appeals
P.O. Box 32040
Oakland, CA 94604

Appeal Process

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

Appeals Determinations

Pre-service and Post-service Claim Appeals

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

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

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

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

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

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

Urgent Claim Appeals that Require Immediate Action

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

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

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

Independent Medical Review
If the **Covered Person** still disagrees with the results of the internal appeal determination, the **Covered Person** may request an Independent Medical Review if the adverse benefit determination involves clinical issues. In order to request an Independent Medical Review, the **Covered Person** must:

Apply for an Independent Medical Review within six months of the qualifying periods or events described below. The Director of the Department of Managed Health Care or Department of Insurance may extend the application deadline beyond six months if the circumstances of a case warrant the extension. The **Covered Person** shall pay no application or processing fees of any kind.

All of the following conditions must be met in order for the **Covered Person** to apply for an Independent Medical Review.

- The **Covered Person's Provider** has recommended a service as medically necessary or the **Covered Person** has received **Emergency Care** that a **Provider** determined was medically necessary or, in the absence of either of the foregoing, the **Covered Person** has been seen by an **In-Network Provider** for the diagnosis or treatment of the condition for which the individual seeks independent review. UBH shall expedite access to an **In-Network Provider** upon request. The **In-Network Provider** does not have to recommend the disputed service as a condition for the individual to be eligible for an independent review. The individual's **Provider** may be an **Out-of-Network Provider**. However, the **Plan** shall have no liability for payment of services provided by an **Out-of-Network Provider**.

- The disputed service has been denied, modified, or delayed based in whole or in part on a decision that the service is not medically necessary.

- The **Covered Person** has filed an appeal with UBH and the disputed decision is upheld or the appeal remains unresolved after 30 days. (A **Covered Person** shall not be required to participate in UBH's appeal process for more than 30 days. If the appeal requires an expedited review, the **Covered Person** shall not be required to remain in the appeal process more than three days.)

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

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

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

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

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

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

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

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

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

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

Coordination of Benefits

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

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

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

Definitions

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

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

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

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

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

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

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

How Coordination Works

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

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

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

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

Which Plan Pays First

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

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a **Medicare** beneficiary and both of the following are true:
  - **Medicare** is secondary to the plan covering the person as a dependent.
  - **Medicare** is primary to the plan covering the person as other than a dependent (for example, as a Retiree).
- 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. (The year of birth is ignored.) This is called the "Birthday Rule."

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

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

Medicare Coordination for Out-of-Network Providers

If the services are covered by **Medicare**, **Medicare** coverage is primary and then the benefits of this **Plan** are calculated on **Medicare** allowance, less **Medicare** payment. If the services are not covered by **Medicare** but they are covered by this Plan, they will be reimbursed in accordance with the **Schedule of Benefits** described on Page 1. The benefits of this **Plan** may be reduced if the **Covered Person** has any other group health, dental, prescription drug or vision coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Facility of Payment

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

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

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

Recovery Provisions

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

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

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

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

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

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

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

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

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

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

Effect of Medicare and Government Plans

Medicare

When a **Covered Person** becomes eligible for **Medicare**, this **Plan** pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law. Because the University is subject to the Medicare Secondary Payer requirements, this Plan will pay primary.

When this Plan Pays Primary to Medicare

This **Plan** pays primary to **Medicare** for **Covered Persons** who are **Medicare-**eligible if:

- Eligibility for **Medicare** is due to age 65 and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.

- Eligibility for **Medicare** is due to disability and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.

- Eligibility for **Medicare** is due to end stage renal disease (ESRD) under the conditions and for the time periods specified by federal law.

When Medicare Pays Primary to this Plan

Medicare pays primary to this **Plan** for **Covered Persons** who are **Medicare**-eligible if:

- The employee is a Retired Employee.

- Eligibility is due to disability and the Employee does NOT have "current employment status" with the employer as defined by federal law and determined by the employer.

- Eligibility for **Medicare** is due to end stage renal disease (ESRD), but only after the conditions and/or time periods specified in federal law cause **Medicare** to become primary.

How this Plan Pays when Medicare is Primary

If **Medicare** pays benefits first, this **Plan** pays benefits as described below. This method of payment only applies to a **Covered Person** who is eligible for **Medicare**. It does not apply to any **Covered Person** unless that **Covered Person** becomes eligible for **Medicare.**

If the **Provider** has agreed to limit charges for services and supplies to the charges allowed by **Medicare** (these **Providers** are referred to as "participating" providers), this **Plan** determines the amount of **Covered Expenses** based on the amount of charges allowed by **Medicare**.

If the **Provider** has not agreed to limit charges for services and supplies to the charges allowed by **Medicare** (these **Providers** are referred to as "non-participating" providers), this **Plan** determines the amount of **Covered Expenses** based on the lesser of the following:

- The **Reasonable Charges**.

- The amount of the Limiting Charge as defined by **Medicare**.

This **Plan** determines the amount payable without regard to **Medicare** benefits. Then this **Plan** subtracts the amount payable under **Medicare** for the same expenses from **Plan** benefits. This **Plan** pays only the difference between **Plan** benefits and **Medicare** benefits. The amount payable under **Medicare** which is subtracted from this **Plan**'s benefits is determined as the amount that would have been payable to a **Covered Person** who is eligible for **Medicare** even if:

- The person is not enrolled for **Medicare** Parts A and B. Benefits are determined as if the person were covered under **Medicare** Parts A and B. This provision does not apply to individuals who properly declined **Medicare** Part B prior to January 1, 2004, as described in the section titled, **Effect of Medicare on Retiree Enrollment**, on pages 7-8 of this Certificate.

- The expenses are paid under another employer's group health plan which is primary to **Medicare**. Benefits are determined as if benefits under that other employer's plan did not exist.

- The person is enrolled in a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) to receive **Medicare** benefits, and receives unauthorized services (out-of-plan services not covered by the HMO/CMP). Benefits are determined as if the services were authorized and covered by the HMO/CMP.

Government Plans (other than Medicare and Medicaid)

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

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

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

Termination of Coverage

Employee Coverage

In addition to the University's provisions set forth in the section titled **Eligibility, Enrollment and Termination Provisions**, the Employee/Retiree's coverage ends on the earliest of the following:

- The day this **Plan** ends.
- The last day of a period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made when due.

Dependent Coverage

Coverage for all of an Employee/Retiree's Dependents ends on the earlier of the following:

- The day the Employee/Retiree's coverage ends.
- The last day of a period for which contributions for the cost of Dependent coverage have been made, if the contributions for the next period are not made when due.

Coverage for an individual Dependent ends on the earlier of:

- The day the Dependent becomes covered as an Employee under this Plan.
- The day the Dependent stops being an eligible Dependent.

Termination Notice

If the **Plan** is terminated, the Company will notify the University in writing. The University will promptly send **Covered Persons** a copy of the termination notice by mail and inform **Covered Persons** of any rights to continue coverage under U.S. Public Law 99-272 (COBRA) or a conversion policy under state law. The University will promptly provide the Company with proof of this mailing.

Continuation of Coverage

Continuation of Coverage for Former Employees Age 60 and Older

An **Employer** subject to COBRA (Consolidated Omnibus Budget Reconciliation Act) shall offer to eligible former **Employee**s and their eligible dependents the opportunity to continue the **Plan's** benefits after COBRA continuation ends, subject to terms and conditions of the **Plan**. The former **Employee** must elect in writing to continue his/her own and his/her spouse's coverage within 30 calendar days prior to the date coverage under COBRA is scheduled to end. The former **Employee** must pay the Company any required premium for the coverage under this provision.

To be eligible, the former **Employee** must:

- Be 60 years of age or older on the date employment ends.
- Have worked for the **Employer** for at least five years prior to the date employment ends.
- Be entitled to and elect to continue benefits under COBRA (U.S. Public Law 99-272).

Coverage will stop on the earliest of the following:

- The date the **Employee** or his/her spouse reaches age 65.
- The date the former **Employer** ceases to maintain any group health plan.
- The date the former **Employee** or his/her spouse is covered under another group health plan not maintained by the University regardless whether that coverage is less valuable.
- The date the former **Employee** or his/her spouse becomes eligible under **Medicare**.
- Five years from the date the former **Employee**'s employment ended, with respect to the **Employee**'s spouse.

Continuation of Coverage for Former Spouses of Employees and Former Employees

If a Former Spouse of an **Employee** or former **Employee** was covered as a qualified beneficiary under COBRA, the Former Spouse may further continue the benefits of this **Plan** beyond the date coverage under COBRA ends, subject to terms and conditions of the **Plan.**

A "Former Spouse" is one of the following:

- An individual divorced from an **Employee** or former **Employee.**
- An individual who was married to an **Employee** or former **Employee** at the time of the death of the **Employee** or former **Employee.**

The Former Spouse must elect in writing to continue his/her coverage within 30 calendar days prior to the date coverage under COBRA is scheduled to end. The Former Spouse must pay the Company any required premium for the coverage under this provision.

The continuation coverage for the Former Spouse will end automatically on the earliest of the following dates:

- The date the individual reaches 65 years of age.
- The date the individual is covered under any group health plan not maintained by the University, regardless whether that coverage is less valuable.
- The date the individual becomes entitled to **Medicare**.
- Five years from the date on which continuation coverage under COBRA was scheduled to end for the Former Spouse.
- The date on which the Employer or former Employer terminates its group contract with the Company and ceases to provide coverage for any active employees through that Company, in which case the Company will notify the former spouse of the right to conversion coverage.

PLAN ADMINISTRATION

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

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

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and the President of the University (or his/her delegates) is the Plan Administrator for the Plan provisions described in this insert to the Plan Evidence of Coverage booklet. If you have a question about eligibility or enrollment, you may direct it to:

University of California
Human Resources
300 Lakeside Drive
Oakland, CA 94612
(800) 888-8267

Retirees and Survivors may also direct questions to the UC Customer Service Center at the above phone number.

Claims and appeals for benefits under the Plan are processed by United Behavioral Health. If you have a question about benefits under the Plan or about a specific claim, please contact United Behavioral Health at the following address and phone number:

United Behavioral Health
P.O. Box 744925
Houston, TX 77274-4925
1-888-440-UCALr (8225)

Group Contract Number

The Group Contract Number for this Plan is: 11280

Type of Plan

This plan provides group medical care benefits. This plan is one of the benefit plans offered under the University of California Health and Welfare Programs for eligible Faculty and Staff.

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

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

Financial Arrangements

The benefits under the Plan are provided by United Behavioral Health under a Group Service Agreement.

The cost of the premiums is currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on United Behavioral Health at the address listed above.

Your Rights under the Plan

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

- Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Group Service Agreement, at a time and location mutually convenient to the participant and the Plan Administrator.

- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan

To file a claim or to file an appeal regarding denied claims of benefits or services, refer to the appeal section found later in this document. Any appeals regarding coverage denials that relate to eligibility requirements are subject to the UC Group Insurance Regulations. To obtain a copy of the Eligibility Claims Appeal Process, please contact the person who handles benefits at your location (or the UC Customer Service Center if you are a retiree).

Nondiscrimination Statement

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

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Glossary

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

Behavioral Health Services
Services and supplies which are:

- **Covered Services** for **Mental Health and Substance Abuse Treatment**.
- Given while the **Covered Person** is covered under the **Plan**.
- Rendered by one of the following providers:
  - Physician.
  - Psychologist.
  - Licensed Counselor.
  - Hospital.
  - Treatment Center.
  - Social Worker.
- **Behavioral Health Services** include but are not limited to the following:
  - Assessment.
  - Diagnosis.
  - Treatment Planning.
  - Medication Management.
  - Individual, family and group psychotherapy.
  - Psychological testing.
- **Telemedicine**. Face-to-face contact is not required between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the Plan.

Calendar Year
A period of one year beginning with January 1.

Clinically Necessary
Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient or physician, or other physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

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

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

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

Covered Person
A Covered Person is a properly enrolled Employee/Retiree and his/her properly enrolled Family Members as described on pages 3-4 of this Certificate.

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 Pays**, and not excluded under the section titled **What's Not Covered-Exclusions**.

Emergency Care
Emergency care is defined as Immediate **Mental Health and Substance Abuse Treatment** when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Care consists of screening, examination and evaluation by a Physician, or other **Provider** to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency, within the capability of the facility.

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

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

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

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

In-Network Provider (also referred to as Network or UBH Network Provider)
A provider who participates in United Behavioral Health's network.

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

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

Medically Necessary
See definition of "**Clinically Necessary**."

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

Mental Health and Substance Abuse Treatment
Mental Health and Substance Abuse Treatment is treatment for the following:

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

All inpatient services, including room and board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a sickness identified in the DSM, are considered **Mental 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 DSM 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**. Usually Prescription Drugs are covered under a separate medical plan. For more information, contact the University at the address shown in **Sponsorship and Administration of the Plan** on page 25.

Non-Routine Outpatient Treatment
Includes but is not limited to psychological testing, ECT (electroconvulsive therapy), extended length therapy sessions (more than 50 minutes), and biofeedback.

Out-of-Network Provider
A provider who does not participate in United Behavioral Health's network.

Physician
A legally qualified:
- Doctor of Medicine (M.D.).
- Doctor of Osteopathy (D.O.).

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

Provider
A person who is qualified and duly licensed or certified, to furnish **Mental Health and Substance Abuse Treatment** independently without supervision, by the state in which he or she is located.

Psychologist
A person who specializes in clinical psychology and fulfills one of these requirements:
- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Reasonable Charge
As to charges for services rendered by or on behalf of an **In-Network** Provider, the Reasonable Charge is an amount not to exceed the amount determined by the Company in accordance with the applicable fee schedule.

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

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

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.

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

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

Telephonic Counseling
Consultation and/or therapy performed over the telephone with a **Covered Person** by a mental health or substance abuse professional.

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

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and the Company.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and board
  - 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.

Utilization Review
A review and determination by United Behavioral Health as to which services and supplies are **Covered Services**.

End of Certificate

IMPORTANT NOTICE

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

IF A DISPUTE CONCERNING A CLAIM ARISES, MEMBERS SHOULD FIRST CONTACT UBH AT 1-888-440-UCAL (8225).

IF THE DISPUTE IS NOT RESOLVED, MEMBERS MAY USE EITHER THE DEPARTMENT OF MANAGED HEALTH CARE OR THE DEPARTMENT OF INSURANCE FOR ASSISTANCE. PHONE NUMBERS FOR BOTH ARE SHOWN BELOW.

CALIFORNIA DEPARTMENT OF INSURANCE: 1-800-927-HELP (1-800-927-4357) IF THE MEMBER LIVES IN CALIFORNIA, OR 1-213-897-8921 IF THE MEMBER LIVES OUTSIDE CALIFORNIA

CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE: 1-888-466-2219.
http://www.hmohelp.ca.gov/

THE MEMBER MAY ALSO CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE AT THE FOLLOWING ADDRESS:

The California Department of Insurance
California Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725
http://www.insurance.ca.gov/

FOR ANY OTHER CONCERNS, PLEASE CONTACT UBH ON THE UC-DEDICATED LINE: 1-888-440-UCAL (8225)

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

English

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in (your language), first call your insurance company's phone number at 1-866-374-6060.
Someone who speaks (your language) can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

Español

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su compañía de seguros. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros al 1-866-374-6060.
Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame a la línea directa del Departamento de seguros al 1-800-927-4357. (Spanish)

中文

重要事項： 您與您的醫生或醫療保險公司交談時，可獲得免費口譯服務。如欲請翻譯員提供 口譯，或欲查詢中文書面資料，請先致電您的保險公司，電話號碼 1-866-374-6060
說中文人士將為您提供協助。如需更多協助，請致電保險部熱線 1-800-927-4357。
(Chinese)

Schedule of Benefits

Effective Date of this Plan **January 1, 2012**

Behavioral Health Benefits for Anthem Blue Cross PPO Members in ARKANSAS[8], MASSACHUSETTS[8], MONTANA[8], OKLAHOMA, PENNSYLVANIA AND SOUTH CAROLINA

Covered Services	**In-Network[1] Providers** **Member Cost Sharing**	**Out-of-Network[2] Providers** **Member Cost Sharing**
Calendar Year Deductible [3]		
Individual	N/A	$500
Family	N/A	$1,500
Annual Out-of-Pocket Maximums (includes deductibles) [4]		
Individual	$3,000	$6,000
Family	$9,000	$18,000
Lifetime Maximum	N/A	N/A
Outpatient (Counseling visits, Structured/Intensive Outpatient care, etc.)	Visits 1-3: No Cost Visits 4+: 20% No cost for children through age 6	Visits 1-3: 20% after deductible Visits 4+: 40%
Inpatient (Facility-based treatment such as Acute care, Residential treatment, Partial hospitalization, etc.)	20%	40% after deductible [5]
Penalty for failure to preauthorize Inpatient treatment [6, 7]	$200	$200

1. To be covered at the In-Network benefit level, services must be Clinically Necessary and provided by a UBH In-Network clinician. Covered Services include outpatient counseling and preauthorized inpatient services (see "Preauthorization Requirement and Utilization Review" section for further information). If inpatient services are not preauthorized, they will be covered after a $200 penalty if it is determined they were Clinically Necessary. The Preauthorization Requirement does not apply to Emergency services.
2. To be covered at the Out-of-Network benefit level, services must be Clinically Necessary, which will be determined through Retrospective Review. Expenses determined not Clinically Necessary will not be covered. Covered Services include outpatient counseling and preauthorized inpatient services (see "Preauthorization Requirement and Utilization Review" section for further information). If inpatient services are not preauthorized, they will be covered after a $200 penalty if it is determined they were Clinically Necessary. The Preauthorization Requirement does not apply to Emergency Services. Out-of-Network member Cost Sharing is 40% of "allowed" charges. "Allowed" Charges are based on the lesser of Reasonable & Customary or billed charges. Charges in excess of "allowed" charges are not covered.
3. Non-Medicare members may use covered Out-of Network Mental Health, Substance Abuse, and Medical expenses to satisfy the Out-of-Network Deductible. Medicare members may use covered Out-of-Network Mental Health and Substance Abuse expenses to satisfy the Out-of-Network Deductible.
4. In-Network and Out-of-Network Out-of-Pocket Maximums are exclusive of each other. Non-Medicare members may use covered In-Network Mental Health, Substance Abuse and Medical expenses to satisfy the In-Network Out-of-Pocket Maximums. Non-Medicare members may use covered Out-of-Network Mental Health, Substance Abuse, and Medical expenses to satisfy the Out-of-Network Out-of-Pocket Maximum. Medicare members may use covered In-Network Mental Health and Substance Abuse expenses to satisfy the In-Network Out-of-Pocket Maximums. Medicare members may use covered Out-of-Network Mental Health and Substance Abuse expenses to satisfy the Out-of-Network Out-of-Pocket Maximum. In addition, for Medicare members, Member In-Network Out-of-Pocket expenses for treatment of conditions defined under California law AB88 as "Severe Mental Illness" will also apply to the In-Network Out-of-Pocket maximum in the member's medical plan. Once the members' medical plan In-Network Out-of-Pocket maximum is met, the member will have no further behavioral health Out-of-Pocket expenses for In-Network treatment of conditions defined as "Severe Mental Illness."
5. Emergency care rendered by an Out-of-Network provider will be paid at the In-Network benefit level. Emergency care is defined as "Immediate Treatment when the lack of treatment could reasonably be expected to result in the patient harming him/herself or another person(s)."
6. The Penalty for Failure to Preauthorize Treatment applies to Inpatient In-Network and Out-of-Network services and is applied per admission/course of treatment. This Penalty is applied before the Covered Person accumulates covered expenses toward the individual Deductible and the Penalty does not apply toward the individual Deductible. If the individual Deductible is satisfied, the Penalty is applied prior to the Plan's percentage payment.

7. The Penalty for Failure to Preauthorize Treatment applies when the plan is not notified in advance of the member receiving non-emergency services.
8. Residents of Arkansas, Massachusetts and Montana may be eligible for additional covered services for treatment of Autism Spectrum Disorders. Please call UBH for details.

Schedule of Benefits

Effective Date of this Plan **January 1, 2012**

Behavioral Health Benefits for Anthem Blue Cross PPO Members in KANSAS

Covered Services	**In-Network[1] Providers** **Member Cost Sharing**	**Out-of-Network[2] Providers** **Member Cost Sharing**
Calendar Year Deductible [3]		
Individual	N/A	$500
Family	N/A	$1,500
Annual Out-of-Pocket Maximums [4]		
Individual	$3,000	$6,000
Family	$9,000	$18,000
Lifetime Maximum	N/A	N/A
Outpatient (Counseling visits, Structured/Intensive Outpatient care, etc.)	Visits 1-3: No Cost Visits 4+: 20% No cost for children through age 6	Visits 1-3: No Cost Visits 4+: 20% No cost for children through age 6
Inpatient (Facility-based treatment such as Acute care, Residential treatment, Partial hospitalization, etc.)	20%	40% after deductible [5]
Penalty for failure to preauthorize Inpatient treatment [6, 7]	$200	$200

1. To be covered at the In-Network benefit level, services must be Clinically Necessary and provided by a UBH In-Network clinician. Covered Services include outpatient counseling and preauthorized inpatient services (see "Preauthorization Requirement and Utilization Review" section for further information). If inpatient services are not preauthorized, they will be covered after a $200 penalty if it is determined they were Clinically Necessary. The Preauthorization Requirement does not apply to Emergency services.
2. To be covered at the Out-of-Network benefit level, services must be Clinically Necessary, which will be determined through Retrospective Review. Expenses determined not Clinically Necessary will not be covered. Covered Services include outpatient counseling and preauthorized inpatient services (see "Preauthorization Requirement and Utilization Review" section for further information). If inpatient services are not preauthorized, they will be covered after a $200 penalty if it is determined they were Clinically Necessary. The Preauthorization Requirement does not apply to Emergency Services. Out-of-Network member Cost Sharing is 40% of "allowed" charges. "Allowed" Charges are based on the lesser of Reasonable & Customary or billed charges. Charges in excess of "allowed" charges are not covered.
3. Non-Medicare members may use covered Out-of Network Mental Health, Substance Abuse, and Medical expenses to satisfy the Out-of-Network Deductible. Medicare members may use covered Out-of-Network Mental Health and Substance Abuse expenses to satisfy the Out-of-Network Deductible.
4. In-Network and Out-of-Network Out-of-Pocket Maximums are exclusive of each other. Non-Medicare members may use covered In-Network Mental Health, Substance Abuse and Medical expenses to satisfy the In-Network Out-of-Pocket Maximums. Non-Medicare members may use covered Out-of-Network Mental Health, Substance Abuse, and Medical expenses to satisfy the Out-of-Network Out-of-Pocket Maximum. Medicare members may use covered In-Network Mental Health and Substance Abuse expenses to satisfy the In-Network Out-of-Pocket Maximums. Medicare members may use covered Out-of-Network Mental Health and Substance Abuse expenses to satisfy the Out-of-Network Out-of-Pocket Maximum. In addition, for Medicare members, Member In-Network Out-of-Pocket expenses for treatment of conditions defined under California law AB88 as "Severe Mental Illness" will also apply to the In-Network Out-of-Pocket maximum in the member's medical plan. Once the members' medical plan In-Network Out-of-Pocket maximum is met, the member will have no further behavioral health Out-of-Pocket expenses for In-Network treatment of conditions defined as "Severe Mental Illness."
5. Emergency care rendered by an Out-of-Network provider will be paid at the In-Network benefit level. Emergency care is defined as "Immediate Treatment when the lack of treatment could reasonably be expected to result in the patient harming him/herself or another person(s)."
6. The Penalty for Failure to Preauthorize Treatment applies to Inpatient In-Network and Out-of-Network services and is applied per admission/course of treatment. This Penalty is applied before the Covered Person accumulates covered expenses

toward the individual Deductible and the Penalty does not apply toward the individual Deductible. If the individual Deductible is satisfied, the Penalty is applied prior to the Plan's percentage payment.

7. The Penalty for Failure to Preauthorize Treatment applies when the plan is not notified in advance of the member receiving non-emergency services.

Schedule of Benefits

Effective Date of this Plan **January 1, 2012**

Behavioral Health Benefits for Anthem Blue Cross PPO Members in LOUISIANA[8], MISSOURI[8], NEW HAMPSHIRE[8] and TEXAS[8]

Covered Services	**In-Network[1] Providers** **Member Cost Sharing**	**Out-of-Network[2] Providers** **Member Cost Sharing**
Calendar Year Deductible[3]		
Individual	N/A	$500
Family	N/A	$1,500
Annual Out-of-Pocket Maximums (includes deductibles) [4]		
Individual	$3,000	$6,000
Family	$9,000	$18,000
Lifetime Maximum	N/A	N/A
Outpatient (Counseling visits, Structured/Intensive Outpatient care, etc.)	Visits 1-3: No Cost Visits 4+: 20% No cost for children through age 6	40% after deductible
Inpatient (Facility-based treatment such as Acute care, Residential treatment, Partial hospitalization, etc.)	20%	40% after deductible [5]
Penalty for failure to preauthorize Inpatient treatment [6, 7]	$200	$200

1. To be covered at the In-Network benefit level, services must be Clinically Necessary and provided by a UBH In-Network clinician. Covered Services include outpatient counseling and preauthorized inpatient services (see "Preauthorization Requirement and Utilization Review" section for further information). If inpatient services are not preauthorized, they will be covered after a $200 penalty if it is determined they were Clinically Necessary. The Preauthorization Requirement does not apply to Emergency services.
2. To be covered at the Out-of-Network benefit level, services must be Clinically Necessary, which will be determined through Retrospective Review. Expenses determined not Clinically Necessary will not be covered. Covered Services include outpatient counseling and preauthorized inpatient services (see "Preauthorization Requirement and Utilization Review" section for further information). If inpatient services are not preauthorized, they will be covered after a $200 penalty if it is determined they were Clinically Necessary. The Preauthorization Requirement does not apply to Emergency Services. Out-of-Network member Cost Sharing is 40% of "allowed" charges. "Allowed" Charges are based on the lesser of Reasonable & Customary or billed charges. Charges in excess of "allowed" charges are not covered.
3. Non-Medicare members may use covered Out-of Network Mental Health, Substance Abuse, and Medical expenses to satisfy the Out-of-Network Deductible. Medicare members may use covered Out-of-Network Mental Health and Substance Abuse expenses to satisfy the Out-of-Network Deductible.
4. In-Network and Out-of-Network Out-of-Pocket Maximums are exclusive of each other. Non-Medicare members may use covered In-Network Mental Health, Substance Abuse and Medical expenses to satisfy the In-Network Out-of-Pocket Maximums. Non-Medicare members may use covered Out-of-Network Mental Health, Substance Abuse, and Medical expenses to satisfy the Out-of-Network Out-of-Pocket Maximum. Medicare members may use covered In-Network Mental Health and Substance Abuse expenses to satisfy the In-Network Out-of-Pocket Maximums. Medicare members may use covered Out-of-Network Mental Health and Substance Abuse expenses to satisfy the Out-of-Network Out-of-Pocket Maximum. In addition, for Medicare members, Member In-Network Out-of-Pocket expenses for treatment of conditions defined under California law AB88 as "Severe Mental Illness" will also apply to the In-Network Out-of-Pocket maximum in the member's medical plan. Once the members' medical plan In-Network Out-of-Pocket maximum is met, the member will have no further behavioral health Out-of-Pocket expenses for In-Network treatment of conditions defined as "Severe Mental Illness."
5. Emergency care rendered by an Out-of-Network provider will be paid at the In-Network benefit level. Emergency care is defined as "Immediate Treatment when the lack of treatment could reasonably be expected to result in the patient harming him/herself or another person(s)."
6. The Penalty for Failure to Preauthorize Treatment applies to Inpatient In-Network and Out-of-Network services and is applied per admission/course of treatment. This Penalty is applied before the Covered Person accumulates covered expenses

toward the individual Deductible and the Penalty does not apply toward the individual Deductible. If the individual Deductible is satisfied, the Penalty is applied prior to the Plan's percentage payment.

7. The Penalty for Failure to Preauthorize Treatment applies when the plan is not notified in advance of the member receiving non-emergency services.
8. Residents of Louisiana, Missouri, New Hampshire and Texas may be eligible for additional covered services for treatment of Autism Spectrum Disorders. Please call UBH for details.

ATTENTION MEMBERS WHO ARE PERMANENT RESIDENTS OF LOUISIANA:

- **Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of these fees for those out-of-network services, in addition to applicable amounts due for co-payments, co-insurance, deductibles, and non-covered services.**
- **Specific information about in-network and out-of-network facility-based physicians can be found at the website address of your health plan or by calling the Customer Service telephone number of your health plan.**