Your Group Plan

UC Care Out-of-Area Plan

United Behavioral Health
Mental Health and Substance Abuse Benefits

Effective January 1, 2001

University of California

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Certification

INSURANCE BOOKLET

for Employees of

University of California

(called the Employer)

insured by

UNITED HEALTHCARE INSURANCE COMPANY
Hartford, Connecticut
(called the Company)

CERTIFICATE OF INSURANCE

United HealthCare Insurance Company has issued Group Policy No. GA-11280. It covers certain Employees of the Employer.

The policy provides Behavioral Health Benefits.

This Certificate of Insurance describes the benefits and provisions of the policy. Additional benefits and provisions may apply based on the requirements of the state where the Employee or Annuitant lives.

These state benefits and provisions are described in separate Amendments. See the Employer for details.

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 or Annuitant is insured under the Employer's Plan for dependent benefits.

This Certificate describes the Plan in effect as of January 1, 2001.

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

Any coverage provided under this certificate is not in place of Workers' Compensation insurance. It does not affect any requirement for coverage by Workers' Compensation insurance.

UNITED HEALTHCARE INSURANCE COMPANY

The Behavioral Health Benefits described in this Plan are administered by United Behavioral Health.

1-888-440-UCAL (8225)

C-CE2, C-SB1, C-MH3CA, C-CI1, C-CB3, C-RP1, C-GL1

Schedule of Benefits

Effective Date of this Plan **January 1, 2001**

Behavioral Health Benefits

Mental Health Copayments	
Office Visit Copayment	**Visits 1-5: $0** **Visits 6+: $10***
Deductible and Out-of-Pocket Maximum	
Substance Abuse Inpatient and Intermediate Care Calendar Year Deductible	**$100**
Mental Health Out-of-Pocket Maximum	**$1,000 per person**** **$3,000 per family****
Percentage Payable after Copayments/Deductibles Satisfied	
Mental Health Inpatient and Intermediate Care	**100%**
Substance Abuse Inpatient: Detoxification	**80%**
Substance Abuse Inpatient and Intermediate Care: Rehabilitation	**80% with Treatment Plan Compliance** **50% without Treatment Plan Compliance**
Mental Health Outpatient	**100% after Copayment**
Substance Abuse Outpatient	**80%**
Maximum Benefits	**None**

*Copayment is waived for children to age six.

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

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

Behavioral Health Benefits

General Information About This Plan

The following sections located at the beginning of this booklet also apply to Behavioral Health Benefits:

--Additional Information Provided by the University of California, except for the section called "Plan Administration"
--Amendment (Rider 1)

Additionally, under "General Information About Your Coverage," the following sections also apply to Behavioral Health Benefits:

--Termination of Coverage
--Continuation of Coverage After COBRA Ceases
--Health Expense Benefits After Termination

What This Plan Pays

Behavioral Health Benefits are payable for Covered Expenses incurred by a Covered Person for Behavioral Health Services received from a Network Provider.

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

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

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

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

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

Behavioral Health Services are services and supplies which are:

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

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

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

Telemedicine

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

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

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

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

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

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

Notification Requirements and Utilization Review

Except for Emergency Care, to receive benefits under this Plan the Covered Person must call United Behavioral Health (UBH) before Behavioral Health Services are given. **The toll-free number is 1-888-440-UCAL (8225). UBH is ready to take the Covered Person's call 7 days a week, 24 hours a day.** This call starts the Utilization Review process. The Covered Person will be referred to a Network Provider who is experienced in addressing his/her specific issues.

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

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

Appeals

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

Emergency Care

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

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

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

Copayments and Deductibles

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

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

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

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

Mental Health Office Visit Copayment

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

Substance Abuse Inpatient and Intermediate Care Calendar Year Deductible

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

Out-of-Pocket Feature

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

Individual Mental Health Out-of-Pocket Maximum

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

Family Mental Health Out-of-Pocket Maximum

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

Not Covered

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

- Services or supplies given by a Non-Network Provider, except when care is received outside the United States.
- Services or supplies which are not Clinically Necessary, including any confinement or treatment given in connection with a service or supply which is not Clinically Necessary.
- Services or supplies received before the Covered Person becomes covered under this Plan.
- Expenses incurred by a Dependent if the Dependent is covered as an Employee or Annuitant for the same services under this Plan.
- Treatment given in connection with any of the following diagnoses: mental retardation (except initial diagnosis), chronic organic brain syndrome, learning disability, or transsexualism.
- Completion of claim forms or missed appointments.
- Custodial Care that has not been approved by UBH. This is care made up of services and supplies that meets one of the following conditions:
    - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
    - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

  Care that meets one of the conditions above is custodial care regardless of any of the following:
    - Who recommends, provides or directs the care.
    - Where the care is provided.
    - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.
- Ecological or environmental medicine, diagnosis and/or treatment.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Services, supplies, medical care or treatment given by one of the following members of the Employee's/Annuitant's immediate family:
    - The Employee's/Annuitant's spouse.
    - The child, brother, sister, parent or grandparent of either the Employee/Annuitant or the Employee's/Annuitant's spouse.
- Services or supplies, treatments or drugs which are considered investigational because they do not meet generally accepted standards of medical practice in the United States. This includes any related confinements, treatment, service or supplies.
- Services and supplies for which the Covered Person is not legally required to pay.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Nutritional counseling.
- Occupational injury or sickness - an occupational injury or sickness is an injury or sickness which is covered under a workers' compensation act or similar law. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.

- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Behavioral Health Services.
- Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-Clinically Necessary purposes, and related expenses for reports, including report presentation and preparation.
- Services given by a pastoral counselor.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners humidifiers, saunas, hot tubs.
- Private duty nursing services while confined in a facility.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Sex-change surgery.
- Stand-by services required by a Physician.
- Telephone consultations.
- Tobacco dependency.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Weight reduction or control (unless there is a diagnosis of morbid obesity), special foods, food supplements, liquid diets, diet plans or any related products.
- Services given by volunteers or persons who do not normally charge for their services.

Network Provider Charges Not Covered

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

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

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

Claims Information

How to File a Claim

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

The following steps should be completed when submitting bills for payment for services and supplies received outside the United States.

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

- The Employee/Annuitant's name, Social Security Number, address and phone number.
- The patients's name.
- The Plan number (11280).
- The name, address and phone number of the provider.
- The licensure of the provider.
- The date of service.
- The place of service.
- The specific services provided.
- The amount charged for the service.
- The diagnosis.

The claim/billing statement should be mailed to:

United Behavioral Health
P.O. Box 23250
Oakland, CA 94623-0250

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

When Claims Must be Filed

The covered Employee/Annuitant 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 Employee/Annuitant will be notified in writing that the claim is contested or denied within 30 working days of receipt of the claim. The notice that the claim is being contested will identify the portion of the claim that is contested and the specific reasons for contesting the claim. If an uncontested claim is not reimbursed by delivery to the claimants' address of record within 30 working days after receipt, interest will accrue at the rate of 10% per year beginning with the first calendar day after the 30-working-day period.

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

Legal Actions

The covered Employee/Annuitant may not sue on a claim before 60 days after proof of loss has been given to the Company. The covered Employee/Annuitant may not sue after three years from the time proof of loss is required, unless the law in the area where the covered Employee/Annuitant 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.

Review Procedure for Denied Claims

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. A request for review must be directed to Appeals Unit, United Behavioral Health - Employer Division at P.O. Box 32040, Oakland, California, 94604, within 60 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, the claimant should state the reason he or she believes the claim was improperly paid or denied and submit any data or comments to support the claim.

A review of the denial will be made and United Behavioral Health will provide the claimant with a written response within 60 days of the date the Company receives the claimant's request for review. If, because of extenuating circumstances, the Company is unable to complete the review process within 60 days, the Company will notify the claimant of the delay within the 60 day period and will provide a final written response to the request for review within 120 days of the date the Company received the claimant's written request for review.

If the denial is upheld, United Behavioral Health's written response to the claimant will cite the specific Plan provision(s) upon which the denial is based.

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.

Please refer to the section called "Coordination of Benefits" in the In Area EOC and the section called "Effect of Medicare" in the Out-of-Area EOC, for the effect of Medicare on this Plan.

Definitions

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

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

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

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

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

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

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

How Coordination Works

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

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

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

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

Which Plan Pays First

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

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:
    - Medicare is secondary to the plan covering the person as a dependent.
    - Medicare is primary to the plan covering the person as other than a dependent (example, an Annuitant).
- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

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

  If the other plan does not have a birthday rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - First, the plan of the parent with custody for the child.
    - Second, the plan of the spouse of the parent with the custody of the child.
    - Finally, the plan of the parent not having custody of the child

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

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.

- The benefits of a plan which covers a person as an employee who is neither laid off nor an Annuitant are determined before those of a plan which covers that person as a laid off employee or an Annuitant. The same rule applies if a person is a dependent of a person covered as an Annuitant or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

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

Right to Exchange Information

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

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

Facility of Payment

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

Right of Recovery

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

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

Recovery Provisions

Refund of Overpayments

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

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

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

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

Reimbursement of Benefits Paid

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

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

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

Subrogation

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

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

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

Plan Administration

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. All of the terms and conditions in your Booklet-Certificate, including but not limited to eligibility and enrollment requirements, must be met in order to be entitled to benefits. Particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

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

Sponsorship and Administration of the Plan

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

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

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

Mental Health & Substance Abuse Benefits

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

United Behavioral Health
P.O. Box 8250
Emeryville, CA 94662-8250
(888) 440-8225

Group Policy Number

11280

Type of Plan

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

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in your Booklet-Certificate but reserves the right to terminate or amend it at any time. The Plan is not a vested plan. The right to terminate or amend applies to all Employees, Annuitants and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premium the University pays is subject to state appropriation which may change or be discontinued in the future.

Financial Arrangements

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

Agent for Serving of Legal Process

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

Your Rights under the Plan

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

- Examine, without charge, at the Plan Administrator's office, or instead of or in addition to, at other locations that may be specified by the Plan Administrator, all Plan documents, including insurance contracts.

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

Mental Health/Substance Abuse

Claims under United Behavioral Health's Mental Health/Substance Abuse Benefit are filed by the United Behavioral Health provider. It is the responsibility of the members to obtain the pre-authorization necessary to receive services from a United Behavioral Health provider.

Nondiscrimination Statement

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

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

Glossary

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

Annuitant

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

Average Regular Paid Time

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

(a) A month with zero regular paid hours which occurred during the Employee's furlough or approved leave without pay will not be included in the calculation of the average. If such absence exceeds eleven (11) months, the averaging will be restarted.

(b) A month with zero regular paid hours which occurred during a period when the Employee was not on furlough or approved leave without pay will be included in the calculation of the average. After two consecutive such months, the averaging will be restarted.

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

(a) If the Employee worked at least 43.75% of the regular paid hours available in the month, the month will be included in the calculation of the average.

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

Calendar Year

A period of one year beginning with January 1.

Covered Person

The Employee or the Annuitant; his or her legal spouse, Domestic Partner or Adult Dependent Relative; and/or Dependent children who are covered under this Plan, except a Survivor Annuitant may not enroll his/her legal spouse.

Course of Treatment

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

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

Emergency Care

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

Employee

A person who is appointed to work at least 50% time for twelve months or more or is appointed at 100% time for three months or more. To remain eligible, an Employee must maintain an Average Regular Paid Time of at least 20 hours per week and maintain an eligible appointment of at least 50% time. If the appointment is at least 50% time, the Employee's 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)."

Health Care Provider

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

Hospital

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

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

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

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

Intermediate Care

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

Licensed Counselor

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

Medicare

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

Mental Disorder Treatment

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

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

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

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

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

Prescription Drugs are not considered Mental Disorder Treatment.

Network Provider

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

Non-Network Provider

A provider which does not participate in the network.

Physician

A legally qualified:

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

Plan

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

Psychologist

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

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

Reasonable Charge

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

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

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

Registered Nurse

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

Substance Abuse Rehabilitation

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

Treatment Center

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

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

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

Treatment Plan Compliance

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

Utilization Review

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

End of Certificate

IMPORTANT NOTICE

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

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

CALL THE CALIFORNIA DEPARTMENT OF INSURANCE AT:

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

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

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

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


Aetna
US Healthcare


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BEHAVIORAL HEALTH