UNIVERSITY OF CALIFORNIA

Behavioral Health Benefits for

Health Net Blue & Gold,
Kaiser Permanente – California
and Western Health Advantage Members

January 1, 2017

Insured by

Unimerica Life Insurance Company

(called the “Company”)

Administered by:

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

Table of Contents

Certification

INSURANCE BOOKLET

for Employees and Retirees of the

UNIVERSITY OF CALIFORNIA

and its affiliates (and their Eligible Family Members)

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

insured by

UNIMERICA LIFE INSURANCE COMPANY

Milwaukee, Wisconsin
(called the Company)

CERTIFICATE OF INSURANCE

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

The policy provides behavioral health benefits.

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

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

This Certificate describes the Plan in effect as of January 1, 2017.

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

UNIMERICA LIFE INSURANCE COMPANY

John M. Prince
President

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

(888) 440-UCAL (8225)

Schedule of Benefits

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

Effective Date of this Plan January 1, 2017

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

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

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

[2] Health Net and WHA members may use covered In-Network Mental Health, Substance Use, Medical, and Pharmacy expenses to satisfy the In-Network Out-of-Pocket Maximums. Kaiser members may use covered In-Network Mental Health and Substance Use expenses to satisfy the In-Network Out-of-Pocket Maximums. Note: Mental health and substance abuse coverage is provided under this plan to Kaiser members as supplemental coverage and, hence, is not necessarily provided in parity with Kaiser's medical/surgical coverage. Kaiser members should refer to their Kaiser plan Evidence of Coverage to learn how using Kaiser's Mental Health benefits will satisfy Kaiser's combined Out-of-Pocket Maximum for both Medical and Mental Health/Substance Abuse expenses and for other differences in the terms and conditions of that plan's coverage.

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

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

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

[6] 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

Note

- Mental health/substance abuse claims for **Emergency Care** 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: Optum Claims, P.O. Box 30760, Salt Lake City, UT 84130-0760.

Eligibility, Enrollment and Termination Provisions

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

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

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

Behavioral Health Benefits

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

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

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

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

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

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

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

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

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

Behavioral Health Services are services and supplies which are:

- **Covered Services**, for **Mental Health and Substance Abuse Treatment**.
- Given while the **Covered Person** is covered under this **Plan**.
- Rendered by one of the following providers:
  - **Physician**
  - **Psychologist**
  - **Licensed Counselor**
  - **Hospital/Facility**
  - **Treatment Center**
  - **Social Worker**
  - **Qualified Autism Service Provider, Professional, Paraprofessional**
  - **Registered Mental Health Psychiatric Nurse**
  - **Advanced Practice Registered Nurse**

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

- Assessment
- Diagnosis
- Medication Management
- Individual, family and group psychotherapy and other psychotherapeutic methods
- Psychological testing.
- Inpatient services, including **Hospital/Facility**-based treatment such as Acute Inpatient, Detoxification services, Residential Treatment, or Recovery Home treatment and any related Inpatient Professional Services.
- Outpatient services, including treatment planning, biofeedback, intensive outpatient services, partial hospitalization/day treatment services, and methadone maintenance.
- Behavioral health treatment for pervasive developmental disorders and autism.
- **Telehealth.** No face-to-face contact is required between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the **Plan**. A definition is provided in the **Glossary**. (This is not the same as **Telephonic Counseling** which is not covered under this plan.)

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

Preauthorization Requirements and Utilization Review

The following requirements apply in cases other than when **Emergency Care** is needed; please see the next section for further information about **Emergency Care.**

Preauthorization of **Non-Routine Outpatient Treatment** is required. These services include, but are not limited to, psychological testing, outpatient ECT (electro-convulsive therapy), extended length therapy sessions (more than 50 minutes in duration, with or without medication management), biofeedback, treatment planning, behavioral health

treatment services for pervasive developmental disorders and autism, Structured/Intensive Outpatient Program treatment, Partial Hospitalization/Day Treatment and methadone maintenance.

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

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

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

When preauthorization is required, initial authorization decisions for urgent services are made as soon as possible to accommodate the clinical condition but not to exceed seventy-two (72) hours of the request, unless there is insufficient information provided to make a coverage determination. The treating provider and facility are notified verbally of the authorization decision within twenty-four (24) hours of the decision. Written notice of the initial authorization for urgent services is transmitted to the member and provider/facility within two (2) business days of the decision, not to exceed seventy-two (72) hours from the time of the request.

When preauthorization is required, initial authorization determinations for non-urgent services are made within five (5) business days of receipt the request. If the request is made by a provider or facility, the requesting provider or facility is notified of the authorization decision by telephone or facsimile within twenty-four (24) hours of the decision. Written notice of the initial authorization for non-urgent care is sent to the member and provider/facility, within two (2) business days of the decision.

Emergency Care

Emergency Care does not require a referral from Optum to an Optum **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 Optum 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 after any applicable copays.

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

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

Copayments

Before behavioral health benefits are payable, each **Covered Person** must satisfy certain Copayment requirements. The amount of each Copayment is shown in the **Schedule of Benefits**.

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

Out-of-Pocket Feature

As shown in the **Schedule of Benefits**, certain **Covered Expenses** are subject to the applicable Copayments until the Out-of-Pocket Maximum has been reached during a **Calendar Year**. Once the member's combined

expenses for mental health, substance abuse, and medical services meet the Out-of-Pocket maximum, the member will have no further Out-of-Pocket expenses for covered mental health, substance abuse, or medical expenses for the rest of that **Calendar Year**. The annual **In-Network** Out-of-Pocket maximums for benefits can be met with covered mental health, substance abuse, and medical expenses.

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

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

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

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

- Gambling Disorder, Neurological Disorders and other conditions with physical basis (e.g. Dementia), Impulse Control Disorder, Sleep Wake Disorder, any "Unspecified Forms" of Disorders, and Binge Eating Disorder.

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM).

- Treatment or services that are medical in nature and covered under a medical plan.

- Prescription drugs or over-the-counter drugs and treatments. Prescription drugs prescribed by your provider may be covered under your prescription drug benefit.

- Services or supplies for Mental Health and Substance Abuse Treatment that are any of the following:
  - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
  - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
  - not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;
  - typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or
  - not consistent with Optum's Level of Care Guidelines or best practices as modified from time to time. Optum may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.

  This exclusion shall not be used to exclude coverage of behavioral health treatments for pervasive developmental disorder or autism as mandated by law except where the treatment goals and objectives for such behavioral treatments have been achieved or are no longer appropriate.

- For adults only, treatment or services, except for the initial diagnoses, for a primary diagnoses of Mental Retardation, Learning, Motor Skills, and Communication Disorders, Conduct Disorder, Dementia, Sexual and Paraphilia Disorders (other than Sexual Identity Disorder), and Personality Disorders, as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably

determined by Optum. This exclusion shall not be read or interpreted to exclude coverage for **Medically Necessary** treatment of pervasive developmental disorders or autism through behavioral health treatments.

- For children only, treatment or services, except for the initial diagnoses, for a primary diagnoses of Mental Retardation, Learning, Motor Skills, and Communication Disorders as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by Optum. This exclusion shall not be read or interpreted to exclude coverage for **Medically Necessary** treatment of pervasive developmental disorders or autism through behavioral health treatments.

- Unproven, Investigational or Experimental Services. These are services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a **Covered Service** if the service, treatment, or device is considered to be unproven, investigational, or experimental. In the event services are denied on the basis of this exclusion the **Covered Person** has the right to appeal through the **Independent Medical Review** process as described herein.

- Custodial Care except for the acute stabilization of the **Covered Person** and returning the **Covered Person** back to his or her baseline levels of individual functioning except that this exclusion does not apply to **Medically Necessary** behavioral health treatment when prescribed for pervasive developmental disorders or autism. Custodial care does not include Acute Inpatient, Detoxification services, Residential Treatment, or Recovery Home treatment and related Inpatient Professional Services. Care is determined to be custodial when:
  - it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the **Covered Person's** competent functioning in activities of daily living; or
  - it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the **Covered Person** to function outside a structured environment. This applies to **Covered Persons** for whom there is little expectation of improvement in spite of any and all treatment attempts.

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

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

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

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

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

- Services or treatment rendered by unlicensed **Providers**, except as may be authorized, permitted, or required by applicable law, including pastoral counselors, or which are outside the scope of the **Providers**' licensure.

- Personal convenience or comfort items including, but not limited to such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
- Light boxes and other equipment including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while confined in a facility.
- Surgical procedures including but not limited to sex transformation operations.
- Smoking cessation related services and supplies.
- Travel or transportation expenses unless Optum has authorized the expenses in advance (or retrospectively in an emergency) for a **Covered Person** to be transferred by ambulance to a mental health or substance abuse facility.
- Services performed by a **Provider** who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the **Provider** may perform on himself or herself.
- Services performed by a **Provider** with the same legal residence as the **Covered Person**.
- **Behavioral Health Services** for which the **Covered Person** has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the **Plan**.
- Charges in excess of any specified **Plan** limitations.
- Any charges for missed appointments.
- Any charges for record processing except as required by law.
- Treatment or services received prior to **Covered Person** being eligible for coverage under the **Plan** or after the date the **Covered Person's** coverage under the **Plan** ends.
- **Telephonic counseling**, therapy performed over the telephone with a **Covered Person** by a mental health or substance abuse professional.

In-Network Provider Charges Not Covered

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

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

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

Claims Information

How to File a Claim

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

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

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

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

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

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

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

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

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

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

The claim/billing statement should be mailed to:

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

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

When Claims Must be Filed

The submission of a claim form either electronically or by mail is necessary to receive payment for the benefits under this plan. The claim may be filed by you or the provider of service. The fully completed claim form must be submitted online or sent to the proper address within 90 days of the date services or supplies for which the claim is made are received. Services received and charges for the services must be itemized, and clearly and accurately described on the form. If it is not possible to submit the claim within that time frame, an extension of up to 12 months may be allowed. However, Optum is not liable for the payment of benefits under this agreement if claims are not filed within the required time period.

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

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

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

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

How and When Claims Are Paid

Optum will make a benefit determination as set forth below. Benefits will be paid to the covered Employee/Retiree as soon as Optum receives satisfactory proof of loss, except in the following cases:

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

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

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

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

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

- The legal guardian of the covered Employee/Retiree's Dependent.

Benefit Determinations

Pre-Service Claims

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

Concurrent Care Claims

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

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

Post-service Claims

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

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

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

Urgent Claims that Require Immediate Attention

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

- The **Covered Person** will receive notice of the benefit determination within 24 hours after Optum receives all necessary information, taking into account the seriousness of the **Covered Person's** condition, 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, Optum will notify the **Covered Person** of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, Optum will notify the **Covered Person** of the information needed within 24 hours after the claim was received. The **Covered Person** then has 48 hours to provide the requested information.

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

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

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

Questions or Concerns about Benefit Determinations

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

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

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

How to Appeal a Claim Decision

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

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

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

The Appeal should be submitted to the following address:

Optum Appeals
P.O. Box 30512
Salt Lake City, UT 84130-0512

Appeal Process

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

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

Appeals Determinations

Pre-service and Post-service Claim Appeals

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

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

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

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

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

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

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

Urgent Claim Appeals that Require Immediate Action

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

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

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

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. Optum 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 Optum and the disputed decision is upheld or the appeal remains unresolved after 30 days. (A **Covered Person** shall not be required to participate in Optum'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 Optum's internal appeals process. The **Covered Person** may not sue after three years from the time proof of loss is required, unless the law in the area where the **Covered Person** lives allows for a longer period of time.

Incontestability of Coverage

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

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

Information and Records

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

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

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

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

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

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

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

Coordination of Benefits

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

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

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

Definitions

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

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

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

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

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

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

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

How Coordination Works

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

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

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

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

Which Plan Pays First

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

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

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

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

Facility of Payment

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

Right of Recovery

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

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

Recovery Provisions

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

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

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

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

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

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

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

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

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

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

Effect of Government Plans

Government Plans (other than Medicare and Medicaid)

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

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

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

Glossary

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

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

Behavioral Health Services
Services and supplies that are:

- **Covered Services** for **Mental Health and Substance Abuse Treatment**.
- Given while the **Covered Person** is covered under the **Plan**.
- Rendered by one of the following providers:
  - **Physician**
  - **Psychologist**
  - **Licensed Counselor**
  - **Hospital/Facility**
  - **Treatment Center**
  - **Social Worker**
  - **Qualified Autism Service Provider, Professional, Paraprofessional**
  - **Registered Mental Health Psychiatric Nurse**
  - **Advanced Practice Registered Nurse**

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

- Assessment
- Diagnosis
- Medication Management
- Individual, family and group psychotherapy and other psychotherapeutic methods
- Psychological testing
- Inpatient services, including **Hospital/Facility**-based treatment such as Acute Inpatient, Detoxification services, Residential Treatment, or Recovery Home treatment and any related Inpatient Professional Services.
- Outpatient services, including treatment planning, biofeedback, intensive outpatient services, partial hospitalization/day treatment services, and methadone maintenance
- Behavioral health treatment for pervasive developmental disorders and autism
- **Telehealth** No face-to-face contact is required between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the Plan.

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

Clinically Necessary
Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient or physician, or other physician.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant

medical community, *Physician Specialty Society* recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors. For these purposes "physician" means all credentialed eligible behavioral health providers which include, but are not limited to, Clinicians, psychiatrists, nurse practitioners, social workers, family therapists, and developmental pediatricians.

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

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

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

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

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

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

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

Hospital/Facility
An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- It is approved by **Medicare** as a hospital.
- It meets all of the following tests:

- It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians.
- It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered graduate nurses.
- It is operated continuously with organized facilities for operative surgery on the premises.

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

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

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

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

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

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

Mental Health and Substance Abuse Treatment
Mental Health and Substance Abuse Treatment is mental health and/or substance abuse treatment for the following:

- Any sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) other than those shown in the **What's not Covered – Exclusions** section, including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause, and
- Any sickness where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.
- Specifically Covered Services shall include the diagnosis and **Medically Necessary** treatment of Severe Mental Illness, which shall include the following conditions:
  - Schizophrenia
  - Schizoaffective disorder
  - Bipolar disorder (manic depressive illness)
  - Major depressive disorders
  - Panic disorder
  - Obsessive-compulsive disorder
  - Pervasive developmental disorder or autism
  - Anorexia nervosa
  - Bulimia nervosa
- In addition, diagnosis and **Medically Necessary** treatment of Serious Emotional Disturbances of a child shall be covered services and shall specifically include any mental disorder identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms.

- If prescribed as **Medically Necessary** for an enrollee with pervasive developmental disorder or autism, behavioral health treatment, meaning professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of the enrollee.

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

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

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

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

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

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

Physician
A legally qualified:

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

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

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

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

Qualified Autism Service Provider
Either of the following:
- A person, entity, or group that is certified by a national entity, such as, but not limited to, the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided

the services are within the experience and competence of the person, entity, or group that is nationally certified including **Qualified Autism Service Professionals** and **Qualified Autism Services Paraprofessionals** as defined by California law.

- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Professional
An individual who meets all of the following criteria:

- Provides Behavioral Health Treatment
- Is employed and supervised by a **Qualified Autism Service Provider**
- Provides treatment pursuant to a treatment plan developed and approved by the **Qualified Autism Service Provider**
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavioral analyst, behavior management assistant, behavior management consultant, or behavioral management program as defined in Section 54342 of title 17 of the California Code of Regulations
- Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code

Qualified Autism Service Paraprofessional
An individual who meets all of the following criteria:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

End of Certificate

IMPORTANT NOTICE

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

IF A DISPUTE CONCERNING A CLAIM ARISES, MEMBERS SHOULD FIRST CONTACT OPTUM AT (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: (800) 927-HELP (800-927-4357) IF THE MEMBER LIVES IN CALIFORNIA, OR (213) 897-8921 IF THE MEMBER LIVES OUTSIDE CALIFORNIA

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

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

State of California
Department of Insurance
Health Claims Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
http://www.insurance.ca.gov/

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

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

English

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

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

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

Español

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

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

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

中文

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

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

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