The Scripps Research Institute

Behavioral Health Benefits

January 1, 2011

Insured By

UnitedHealthcare Insurance Company

Administered By
United Behavioral Health
Certificate of Coverage
UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy
This Certificate of Coverage (Certificate) is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges. United Behavioral Health (UBH) administers all Benefits described in this Certificate, the Schedule of Benefits, Riders, and Amendments.

In addition to this Certificate the Policy includes:
- The Group Policy.
- The Schedule of Benefits.
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document
We may from time to time modify this Certificate by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Certificate. When that happens we will send you a new Certificate, Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have
We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

This Certificate describes Benefits in effect as of January 1, 1998 for the Enrolling Group.

On its effective date this Certificate replaces and overrules any Certificate that we may have previously issued to you. This Certificate will in turn be overruled by any Certificate we issue to you in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of California. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of California are the laws that govern the Policy.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR FROM WHICH GROUP OF PROVIDERS BEHAVIORAL HEALTH SERVICES MAY BE OBTAINED.
Introduction to Your Certificate

We are pleased to provide you with this Certificate. This Certificate and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your Certificate and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Certificate by reading the attached Schedule of Benefits along with Section 1: Covered Behavioral Health Services and Section 2: Exclusions and Limitations. You should also carefully read Section 8: General Legal Provisions to better understand how this Certificate and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of the Certificate are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Certificate and Schedule of Benefits and any attachments in a safe place for your future reference.

If there is a conflict between this Certificate and any summaries provided to you by the Enrolling Group, this Certificate will control.

Please be aware that your Clinician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Certificate is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in Section 9: Defined Terms. You can refer to Section 9: Defined Terms as you read this document to have a clearer understanding of your Certificate.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company or our administrator, United Behavioral Health (UBH). When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in Section 9: Defined Terms.

Don’t Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for Customer Service listed on your ID card. It will be our pleasure to assist you.
Your Responsibilities

Be Enrolled and Pay Required Contributions
Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in Section 3: When Coverage Begins. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in Section 9: Defined Terms.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

Be Aware this Benefit Plan Does Not Pay for All Health Services
Your right to Benefits is limited to Covered Behavioral Health Services. The extent of this Benefit plan's payments for Covered Behavioral Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Behavioral Health Services is set forth in the Schedule of Benefits.

Decide What Services You Should Receive
Care decisions are between you and your Clinicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Clinician
It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Clinicians and health care facilities to participate in a Network. Our credentialing process confirms public information about the Clinicians' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Pay Your Share
You must pay a Copayment and/or Coinsurance for most Covered Behavioral Health Services. These payments are due at the time of service or when billed by the Clinician or facility. Copayment and Coinsurance amounts are listed in the Schedule of Benefits. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services
You must pay the cost of all excluded services and items. Review Section 2: Exclusions and Limitations to become familiar with this Benefit plan's exclusions.

Show Your ID Card
You should show your identification (ID) card every time you request Mental Health or Substance Use Disorder Services. If you do not show your ID card, the Clinician may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.
File Claims with Complete and Accurate Information

When you receive Covered Behavioral Health Services from a non-Network Clinician, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in Section 5: How to File a Claim.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for Mental Health or Substance Use Disorder Services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Behavioral Health Services that are not related to the condition or disability for which you have other coverage.
Our Responsibilities

Determine Benefits
We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a behavioral health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Certificate, the Schedule of Benefits, and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Behavioral Health Services
We pay Benefits for Covered Behavioral Health Services as described in Section 1: Covered Behavioral Health Services and in the Schedule of Benefits, unless the service is excluded in Section 2: Exclusions and Limitations. This means we only pay our portion of the cost of Covered Behavioral Health Services. It also means that not all of the behavioral health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Clinicians
It is the responsibility of Network Clinicians and facilities to file for payment from us. When you receive Covered Behavioral Health Services from Network Clinicians, you do not have to submit a claim to us.

Pay for Covered Behavioral Health Services Provided by Non-Network Clinicians
In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See Section 5: How to File a Claim.

Refer to the Schedule of Benefits to determine whether or not your Benefit plan offers Non-Network Benefits for Mental Health or Substance Use Disorder Services performed by non-Network Clinicians.

Submission of a request for payment does not guarantee payment of Benefits. We have the right to retrospectively review any claim, regardless of pre-certification requirements, to determine, through our Utilization Review process, if the service received, in whole or in part, was Medically Necessary. Services received from non-Network Clinicians usually result in higher financial responsibility for the Covered Person.

Review and Determine Benefits in Accordance with our Reimbursement Policies
We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
As reported by generally recognized professionals or publications.

As used for Medicare.

As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. Network providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed.
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Section 1: Covered Behavioral Health Services

Benefits for Covered Behavioral Health Services

Benefits are available only if all of the following are true:

- Covered Behavioral Health Services are received while the Policy is in effect.
- Covered Behavioral Health Services are received prior to the date that any of the individual termination conditions listed in Section 4: When Coverage Ends occurs.
- The person who receives Covered Behavioral Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Behavioral Health Services for which Benefits are available. Please refer to the attached Schedule of Benefits for details about:

- The amount you must pay for these Covered Behavioral Health Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Behavioral Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining pre-certification.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Behavioral Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Behavioral Health - Mental Health Services - Inpatient and Intermediate

Mental Health Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, including:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Services received in a Residential Treatment Facility.
- Partial Hospitalization/Day Treatment.

UBH, who will authorize the services, will determine coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

One Inpatient day is equivalent to:
- Two sessions of Partial Hospitalization/Day Treatment.
- Five sessions of Intensive Outpatient Treatment.
- Six outpatient visits.
- Ten days of Transitional Care.

Mental Health Services must be authorized and overseen by UBH. Referrals to a Mental Health Services provider are at the discretion of UBH, who is responsible for coordinating all of your care. Contact UBH regarding Benefits for Inpatient/Intermediate Mental Health Services. Services will not be considered Covered Behavioral Health Services solely because the services were prescribed by a Clinician.

Special Mental Health Programs and Services

Special programs and services that are contracted under UBH may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient treatment, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient treatment or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through UBH, who is responsible for coordinating your care. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

3. Behavioral Health - Mental Health Services - Outpatient

Mental Health Services received on an outpatient basis in a Clinician's office or at an Alternate Facility, including:
- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Intensive Outpatient Treatment.
- Psychological testing.

Mental Health Services must be authorized and overseen by UBH. Referrals to a Mental Health Services provider are at the discretion of UBH, who is responsible for coordinating all of your care. Contact UBH regarding Benefits for outpatient Mental Health Services.

A UBH behavioral health professional is available 24 hours per day to provide assessment services to assist you in finding the most appropriate services and provider. Services will not be considered Covered Behavioral Health Services solely because the services were prescribed by a Clinician.

Special Mental Health Programs and Services
Special programs and services that are contracted under UBH may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient treatment, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient treatment or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through UBH, who is responsible for coordinating your care. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

4. Behavioral Health - Substance Use Disorder Services - Inpatient and Intermediate

Substance Use Disorder Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, including:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Services received in a Residential Treatment Facility.
- Inpatient Detoxification (sub-acute/non-medical).
- Partial Hospitalization/Day Treatment.

UBH, who will authorize the services, will determine coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

One Inpatient day is equivalent to:

- Two sessions of Partial Hospitalization/Day Treatment.
- Five sessions of Intensive Outpatient Treatment.
- Six outpatient visits.
- Ten days of Transitional Care.

Substance Use Disorder Services must be authorized and overseen by UBH. Referrals to a Substance Use Disorder Services provider are at the discretion of UBH, who is responsible for coordinating all of your care. Contact UBH regarding Benefits for Inpatient/Intermediate Substance Use Disorder Services. Services will not be considered Covered Behavioral Health Services solely because the services were prescribed by a Clinician.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under UBH may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient treatment, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient treatment or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under the Policy. You must be referred to such programs through UBH, who is responsible for coordinating your care. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.
5. Behavioral Health - Substance Use Disorder Services - Outpatient

Substance Use Disorder Services received on an outpatient basis in a Clinician's office or at an Alternate Facility, including:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Intensive Outpatient Treatment.
- Outpatient detoxification.

Substance Use Disorder Services must be authorized and overseen by UBH. Referrals to a Substance Use Disorder Services provider are at the discretion of UBH, who is responsible for coordinating all of your care. Contact UBH regarding Benefits for outpatient Substance Use Disorder Services.

A UBH behavioral health professional is available 24 hours per day to provide assessment services to assist you in finding the most appropriate services and provider. Services will not be considered Covered Behavioral Health Services solely because the services were prescribed by a Clinician.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under UBH may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient treatment, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient treatment or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under the Policy. You must be referred to such programs through UBH, who is responsible for coordinating your care. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

6. Behavioral Health - Mental Health and Substance Use Disorder Services - Outpatient Emergency Behavioral Health Services

Services that are required to stabilize or initiate treatment in an Emergency as provided by or under the direction of a Physician. Emergency Behavioral Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your mental health and/or substance use disorder or condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

7. Neurobiological Disorders - Autism Spectrum Disorders

Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric Clinician.
Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

Benefits include the following services provided on an inpatient basis:

- Services received in a Residential Treatment Facility.
- Partial Hospitalization/Day Treatment.

UBH, who will authorize the services, will determine coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.
Section 2: Exclusions and Limitations

How We Use Headings in this Section
To help you find specific exclusions more easily, we use headings (for example A. Behavioral Health - Mental Health below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions
We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Clinician or other provider.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Behavioral Health Services, except as may be specifically provided for in Section 1: Covered Behavioral Health Services or through a Rider to the Policy.

Benefit Limitations
When Benefits are limited within any of the Covered Behavioral Health Service categories described in Section 1: Covered Behavioral Health Services, those limits are stated in the corresponding Covered Behavioral Health Service category in the Schedule of Benefits. Limits may also apply to some Covered Behavioral Health Services that fall under more than one Covered Behavioral Health Service category. When this occurs, those limits are also stated in the Schedule of Benefits under the heading Benefit Limits. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say “this includes,” it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list “is limited to.”

A. Behavioral Health - Mental Health
Exclusions listed directly below apply to services described under Mental Health Services in Section 1: Covered Behavioral Health Services.

3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
for autism spectrum disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1: Covered Health Services.

8. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of UBH, are any of the following:
   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   - Not consistent with UBH's level of care guidelines or best practices as modified from time to time.
   - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.
   - Not Medically Necessary.

9. Neuropsychological testing when not required for the diagnosis of a Mental Illness, substance use disorder, or developmental disability.

B. Behavioral Health - Substance Use Disorders
Exclusions listed directly below apply to services described under Substance Use Disorder Services in Section 1: Covered Behavioral Health Services.

2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of UBH, are any of the following:
   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   - Not consistent with UBH's level of care guidelines or best practices as modified from time to time.
   - Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.
   - Not Medically Necessary.
5. Neuropsychological testing when not required for the diagnosis of a Mental Illness, substance use disorder, or developmental disability.

C. Drugs
1. Prescription drug products of any kind, including prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Over-the-counter drugs and treatments.
D. Experimental or Investigational or Unproven Services
Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

E. Neurobiological Disorders - Autism Spectrum Disorders
Exclusions listed directly below apply to services described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1: Covered Behavioral Health Services.


2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.


4. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder.

5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.

6. Intensive Behavioral Therapies such as applied behavioral analysis for Autism Spectrum Disorder.

7. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of UBH, are any of the following:
   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   - Not consistent with UBH's level of care guidelines or best practices as modified from time to time.
   - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.
   - Not Medically Necessary.]

8. Neuropsychological testing when not required for the diagnosis of a Mental Illness, substance use disorder, or developmental disability.

F. Providers
1. Services performed by a Clinician or other provider who is a family member by birth, adoption or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Except as required by law, services performed by unlicensed clinicians or which are outside the scope of a Clinician's licensure.
4. For Benefit plans that do not offer Non-Network Benefits, services performed by a non-Network Clinician unless required as Emergency Behavioral Health Services.

G. Services Provided under another Plan
1. Behavioral health services required by law to be provided by a school, municipal, county, state or federal agency or other government agency or for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include school-based services or coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any behavioral health services that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Behavioral health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Behavioral health services while on active military duty.

H. Travel
1. Behavioral health services provided in a foreign country, unless required as Emergency Behavioral Health Services.

2. Travel or transportation expenses, even though prescribed by a Clinician, except as described in Section 1:Covered Behavioral Health Services under Ambulance Services.

I. All Other Exclusions
1. Health services and supplies that do not meet the definition of a Covered Behavioral Health Service - see the definition in Section 9: Defined Terms.

2. Examinations, testing or treatments that are otherwise covered under the Policy when:
   - Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.

3. Behavioral health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Services received after the date your coverage under the Policy ends. This applies to all Mental Health or Substance Use Disorder Services, even if the service is required to treat a condition that arose before the date your coverage under the Policy ended.

5. Services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.

7. Charges in excess of Eligible Expenses or in excess of any specified limitation.

8. Custodial Care.
9. Herbal medicine, herbal drugs, holistic or homeopathic treatment, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.

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

11. Weight reduction or weight control programs.

12. Supplies, equipment and similar incidental services and supplies for personal care, comfort or convenience. Examples include but are not limited to:
   - Air conditioners and air purifiers.
   - Beauty/barber service.
   - Exercise equipment.
   - Guest service.
   - Personal computer.
   - Telephone.
   - Television.

13. Equipment including light boxes, durable medical equipment, medical devices, supplies, or appliances of any kind whether associated with a behavioral or non-behavioral condition.

14. Private duty nursing.

15. Surgical procedures including, but not limited to, gender reassignment operations and procedures.

16. Services for the treatment of nicotine use, including smoking cessation related programs, services and supplies.

17. Charges for missed appointments.

18. Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation programs or lifestyle programs, including any services provided in conjunction with, or as a part of, such programs.

19. Speech therapy, occupational therapy, physical therapy, Intensive Behavioral Therapies and any other rehabilitative or habilitative therapy services.

20. Tuition for or services that are school-based for children and adolescents under the Individuals with Disability Education Act.
Section 3: When Coverage Begins

How to Enroll
Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit electronic eligibility files to us, along with any required Premium. We will not provide Benefits for services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins
If you are an inpatient in a Hospital on the day your coverage begins, we will pay Benefits for Covered Behavioral Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Behavioral Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Behavioral Health Services from Network Clinicians.

Who is Eligible for Coverage
The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person
Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see Section 9: Defined Terms.

Eligible Persons must reside within the United States.

Dependent
Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see Section 9: Defined Terms.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If the Subscriber is required by a court or administrative order to provide health coverage for the Subscriber's Dependent child, the child will be able to be enrolled regardless of any enrollment season restriction. We will enroll the child upon application for enrollment by the custodial parent, the non-custodial parent, the Medi-Cal program, or the local child support agency.

We will not cancel or revoke enrollment of the child, or eliminate coverage, unless one of the following happens:

- The Enrolling Group receives satisfactory written evidence that the order requiring coverage is no longer in effect.
- The Enrolling Group receives confirmation that the child is enrolled in other comparable coverage that will take effect not later than the effective date of termination of coverage under this Policy.
- The Enrolling Group has eliminated dependent health coverage for all its Subscribers.
- The Subscriber is no longer eligible for coverage.

We will notify both parents and any other person having custody of a child in writing at any time that health insurance for the child is terminated.
When a child is enrolled in a plan of the non-custodial parent or a parent sharing custody or temporary control of the child, we will:

- Provide the custodial parent with any information necessary to obtain Benefits and services for the child.
- Allow the custodial parent or the health care provider with the custodial parent's approval, to submit claims for Benefits, without the approval of the non-custodial parent.

Make claim payments directly to the person or entity who submitted the claim, that is, the custodial parent, the health care provider, or the Medi-Cal program.

**When to Enroll and When Coverage Begins**

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

**Initial Enrollment Period**

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the electronic eligibility files and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

**Open Enrollment Period**

The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Enrolling Group if we receive the electronic eligibility files and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

**Dependent Child Special Open Enrollment Period**

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if we receive the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

**New Eligible Persons**

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the electronic eligibility files and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

**Adding New Dependents**

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
• Court or administrative order.
• Registering a Domestic Partner.

Coverage for the Dependent begins on the date of the event if we receive the electronic eligibility files and any required Premium within 31 days of the event that makes the new Dependent eligible.

Special Enrollment Period
An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:
• Birth.
• Legal adoption.
• Placement for adoption.
• Marriage.
• Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:
• The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or Children’s Health Insurance Program (CHIP). Coverage will begin only if we receive the electronic eligibility files and any required Premium within 60 days of the date of determination of subsidy eligibility.
• The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
• Coverage under the prior plan ended because of any of the following:
  ▪ Loss of eligibility (including, but not limited to, legal separation, divorce or death).
  ▪ The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  ▪ In the case of COBRA continuation coverage, the coverage ended.
  ▪ The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  ▪ The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
  ▪ An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
  ▪ The Eligible Person and/or Dependent loses eligibility under Medicaid or Children’s Health Insurance Program (CHIP). Coverage will begin only if we receive the electronic eligibility files and any required Premium within 60 days of the date coverage ended.
When an event takes place (for example, a birth, marriage, or determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the electronic eligibility files and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the electronic eligibility files and any required Premium within 31 days of the date coverage under the prior plan ended.
Section 4: When Coverage Ends

General Information about When Coverage Ends
We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving treatment on that date.

When your coverage ends, we will still pay claims for Covered Behavioral Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any Mental Health Services or Substance Use Disorder Services received after that date (even if the condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Please note that for Covered Persons who are subject to the Extended Coverage for Total Disability provision later in this section, entitlement to Benefits ends as described in that section.

Events Ending Your Coverage
Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**
  Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**
  Your coverage ends on the date you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 9: Defined Terms for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**
  Your coverage ends on the date we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**
  Your coverage ends the date the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

  This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group’s application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage
When either of the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**
You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Threatening Behavior**
  You committed acts of physical or verbal abuse that pose a threat to our staff.

**Coverage for a Disabled Dependent Child**
Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following criteria are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of a physically or mentally disabling Injury, illness, or condition.
- Depends chiefly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will notify the Subscriber that the Enrolled Dependent child's coverage will end upon attainment of the limiting age unless the Subscriber submits proof of the criteria described above to us within 60 days of the date of receipt of our notification. We will send this notification to the Subscriber at least 90 days prior to the date the Enrolled Dependent child attains the limiting age. Upon receipt of the request of the Subscriber for continued coverage of the child and proof of the criteria described above, we will determine whether the Enrolled Dependent child meets the criteria before the child attains the limiting age. If we fail to make the determination by that date, coverage of the Enrolled Dependent child will continue pending our determination.

We may continue to ask you for proof that the child continues to be disabled and dependent. However, we will not ask for this information more than once a year following the initial two year period following the child's attainment of the limiting age.

**Extended Coverage for Total Disability**
[Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Three months from the date coverage would have ended when the entire Policy was terminated.

**Continuation of Coverage and Conversion**
If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.
We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

**Extension of Continuation under State Law (Cal-COBRA) after Exhaustion of Federal COBRA Continuation Coverage**

A Qualified Beneficiary is an individual who was covered under the Policy and has also exhausted their continuation coverage under Federal law (COBRA) for which they were entitled to less than 36 months of coverage. Extended continuation coverage under state law (Cal-COBRA) may be obtained for up to 36 months from the date that the COBRA continuation began.

**Qualifying Events for Extended Coverage**

The date of your "Qualifying Event" is the date that continuation coverage began under your federal COBRA continuation.

**Notification and Election Rights**

Notification of any right to extended coverage under Cal-COBRA will be provided to you by the Enrolling Group or the Enrolling Group's designated plan administrator within 90 days prior to your termination under COBRA. Continuation must be elected within 30 days of when COBRA continuation is scheduled to end.

The Enrolling Group or the Enrolling Group's designated plan administrator will notify us of your election to extend your continuation coverage under Cal-COBRA.

**Termination of Extended Continuation Coverage**

Continuation under the Policy will end on the earliest of the following dates:

- Thirty-six months from the date of your qualifying event.
- The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare.
- The date, after electing continuation coverage that the Qualified Beneficiary has other hospital, medical or surgical coverage, or is or becomes covered under another group health plan.
- The date the Qualified Beneficiary is covered, becomes covered, or is eligible for coverage pursuant to Chapter 6A of the Public Health Service Act.
- The date coverage terminated under the Policy for failure to make timely payment of the Premium.
- The date the entire Policy ends.
- The date coverage would otherwise terminate under the Policy as described in this section under the heading *Events Ending Your Coverage*.

**Conversion**

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability. Conversion coverage is not required when the Covered Person is terminated under the Policy for any of the following reasons:

- You or the Enrolling Group failed to make any required contributions toward the coverage.
You or the Enrolling Group were terminated by us from the Policy for good cause.

You or the Enrolling Group knowingly furnished incorrect information or otherwise improperly obtained Benefits under the Policy.

The Policy ends and replacement coverage is provided within 60 days of termination.

Conversion coverage is not required to be provided to you if any of the following facts are present:

- You are covered by or are eligible for benefits under title XVIII of the United States Social Security Act.
- You are covered by or are eligible for hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured.
- You are covered for similar benefits by an individual policy or contract.
- You have not been continuously covered under the Policy (or any prior group plan with similar coverage) during the three month period immediately preceding your termination of coverage.
- Notification of your right to conversion coverage will be provided to you by the Enrolling Group within 15 days of the date of termination.
- Benefits provided under your conversion coverage will be at least the minimum benefits as required for major medical conversion coverage as required by the California Insurance Code.

Application and payment of the initial Premium must be made within 63 days after coverage ends under the Policy. Coverage will be effective on the day following the termination of coverage under the Policy. Conversion coverage will be provided for you and any Enrolled Dependents. Coverage will be issued in accordance with the terms and conditions in effect at the time of application.
Section 5: How to File a Claim

If You Receive Covered Behavioral Health Services from a Network Clinician
We pay Network Clinicians directly for your Covered Behavioral Health Services. If a Network Clinician bills you for any Covered Behavioral Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network Clinician at the time of service, or when you receive a bill from the Clinician.

If You Receive Covered Behavioral Health Services from a Non-Network Clinician
When you receive Covered Behavioral Health Services from a non-Network Clinician, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you request, we will provide claims forms to you within 15 days of your request. If you do not request such a claim form, you may submit the required information as provided below. If you don’t provide this information to us within one year of the date of service, Benefits for that service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information
When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- A diagnosis from the Clinician.
- An itemized bill from your Clinician that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the behavioral health condition or illness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits
We will pay Benefits within 30 days after we receive your request for payment that includes all required information.

We will reimburse claims or any portion of any claim, whether instate or out-of-state, for Covered Health Services, as soon as possible, no later than 30 working days after receipt of the claim.

However, a claim or portion of a claim may be contested or denied by us. In that case you 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 or denied will identify the portion of the claim that is contested or denied and the specific reasons including, for each reason, the factual and legal basis known at the time by us for contesting or denying the claim. If the reason is based solely on facts or solely on law, we will provide
only the factual or the legal basis for contesting or denying the claim. We will provide a copy of such notice to each Covered Person who received services pursuant to the claim that was contested or denied and the health care provider that provided the services at issue.

If an uncontested claim is not reimbursed by delivery to your address of record within 30 working days after receipt, we will pay interest at the rate of 10% per annum beginning with the first calendar day after the 30-working-day period.

If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a Clinician may be paid directly to the Clinician instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by other Clinicians.

Benefits will be paid to you unless either of the following is true:

- The Clinician notifies us that your signature is on file, assigning benefits directly to that Clinician.
- You make a written request at the time you submit your claim.
Section 6: Questions, Complaints and Appeals

Important Notice - Claim Disputes
Should a dispute concerning a claim arise, contact United Behavioral Health (UBH) first. If the dispute is not resolved, contact the California Department of Insurance.

Call us at the phone number shown on your ID card.

Call the California Department of Insurance at:

- 1-800-927 HELP (1-800-927-4357) if you reside in the State of California.
- 213-897-8921 if you reside outside of the State of California.
- You 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

For further information about complaint procedures please read the section below.

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question
Contact United Behavioral Health (UBH) Customer Service at the telephone number shown on your ID card. UBH Customer Service representatives are available to take your call during regular business hours, Monday through Friday. They can provide information regarding eligibility, ID cards, Networks, Benefits and claims status.

What to Do if You Have a Complaint
Contact UBH Customer Service at the telephone number shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to UBH in writing, the Customer Service representative can provide you with the appropriate address.

If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. UBH will notify you of its decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims
Post-service claims are those claims that are filed for payment of Benefits after care has been received.

Pre-service Requests for Benefits
Pre-service requests for Benefits are those requests that require pre-certification or authorization prior to receiving behavioral health services.
How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, a post-service claim determination or a rescission of coverage determination, you can contact UBH in writing to formally request an appeal.

Your request for an appeal should include:

- The patient’s name and the identification number from the ID card.
- The date(s) of behavioral health service(s).
- The provider’s name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to UBH within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial. For post-service claim appeals, you should send your appeal to the address shown on the explanation of benefits (EOB) form you received regarding the initial claim determination. For pre-service appeals, send your appeal to the following address:

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

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. UBH may consult with, or seek the participation of, behavioral health and medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent behavioral health and medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see Urgent Appeals that Require Immediate Action below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days of the date we received your request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request, along with a copy of the letter regarding the initial appeal decision, must be submitted to the address set forth in that letter within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days of the date we received your request for review of the first level appeal decision.
For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days of the date we received your request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request, along with a copy of the letter regarding the initial appeal decision, must be submitted to the address set forth in that letter within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days of the date we received your request for review of the first level appeal decision.

**Urgent Appeals that Require Immediate Action**

Your appeal may require immediate action when your Clinician reasonably concludes that the normal appeal time frames could significantly increase the risk to your life or health, or the ability to regain maximum function, or cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Clinician should call UBH at the number on the back of your ID card as soon as possible.
- UBH will provide you with a written or electronic determination within 72 after your request for review of the determination is received, taking into account the seriousness of your condition.
- If UBH needs more information from your Clinician to make a decision, UBH will notify you of the decision by the end of the next business day following receipt of the required information.
- If, after you receive the decision on your urgent appeal, you would like UBH to consider the matter again, you or your Clinician should call UBH immediately at the number on the back of your ID card.

The appeal process for urgent situations does not apply to prescheduled treatments.

**A Second Opinion May Be Required**

In the event of a question or dispute regarding your right to Benefits, UBH may require that a Network Clinician of UBH's choice examine you at our expense. In order to pursue your dispute, you must submit to such an examination.

**Federal External Review Program**

The *Departments of Health and Human Services, Labor and Treasury (Departments)* will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been established by the *Departments*, UBH will provide you with additional information concerning the process.

Contact UBH at the telephone number on the back of your ID card for more information on the Federal external review program.
Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan
This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies
This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions
For purposes of this section, terms are defined as follows:

A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.
D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations
are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
      (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
      (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
      (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         (a) The Plan covering the Custodial Parent.
         (b) The Plan covering the Custodial Parent's spouse.
         (c) The Plan covering the non-Custodial Parent.
         (d) The Plan covering the non-Custodial Parent's spouse.
c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will
then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

**Right of Recovery**

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

**When Medicare is Secondary**

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.
Section 8: General Legal Provisions

Your Relationship with Us
In order to make choices about your behavioral health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide behavioral health services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Clinician make those decisions.
- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the behavioral health care that you may receive. The plan pays for Covered Behavioral Health Services, which are more fully described in this Certificate.
- The plan may not pay for all treatments you or your Clinician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our Notice of Privacy Practices for details.

Our Relationship with Clinicians and Enrolling Groups
The relationships between us and Network Clinicians and Enrolling Groups are solely contractual relationships between independent contractors. Network Clinicians and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network Clinicians or the Enrolling Groups.

We do not provide behavioral health services or supplies, nor do we practice medicine. Instead, we arrange for behavioral health care Clinicians to participate in a Network and we pay Benefits. Network Clinicians are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the Clinicians' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network Clinicians such as principal-agent or joint venture. We are not liable for any act or omission of any Clinician.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the Employee Benefits Security Administration, U. S. Department of Labor.
Your Relationship with Clinicians and Enrolling Groups
The relationship between you and any Clinician is that of Clinician and patient.

- You are responsible for choosing your own Clinician.
- You are responsible for paying, directly to your Clinician, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your Clinician, the cost of any non-Covered Behavioral Health Service.
- You must decide if any Clinician treating you is right for you. This includes Network Clinicians you choose and Clinicians to whom you have been referred.
- You must decide with your Clinician what care you should receive.
- Your Clinician is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice
When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber
All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Clinicians
We pay Network Clinicians through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network Clinicians are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- Capitation - a group of Network Clinicians receives a monthly payment from us for each Covered Person who selects a Network Clinician within the group to perform or coordinate certain behavioral health services. The Network Clinicians receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network Clinicians. From time to time, the payment method may change. If you have questions about whether your Network Clinician's contract with us includes any financial incentives, we encourage you to discuss those questions with your Clinician. You may also contact us at the telephone number on your ID card. We can advise whether your Network Clinician is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.
Incentives to You
Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Clinician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Interpretation of Benefits
We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this Certificate, the Schedule of Benefits, and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Behavioral Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services
We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing or Utilization Review. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy
To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records
We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our Notice of Privacy Practices.
By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your behavioral health Clinician. Clinicians may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons
In the event of a question or dispute regarding your right to Benefits, we may require that a Network Clinician of our choice examine you at our expense.

Workers’ Compensation not Affected
Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers’ compensation insurance.

Reimbursement – Right to Recovery
In consideration of the coverage provided under the Policy, we shall have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, if you make a recovery from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.
- These third parties and persons or entities are collectively referred to as “Third Parties”.

You agree as follows:
- That you will cooperate with us in protecting our right to reimbursement, including, but not limited to:
  - providing any relevant information requested by us.
  - signing and/or delivering such documents as we or our agents reasonably request to secure the reimbursement claim.
  - responding to requests for information about any accident or injuries.
- making court appearances.

- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.

- That we have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- That no court costs or attorneys’ fees may be deducted from our recovery without our express written consent; and so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys’ fees to the attorney hired by you to pursue your damage/personal injury claim.

- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.

- That benefits paid by us may also be considered to be benefits advanced.

- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.

- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.

- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.

- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's injury, the terms of this reimbursement clause shall apply to that claim.

### Refund of Overpayments

If we pay 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 us if any of the following apply:

- 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 we made exceeded the Benefits under the Policy.

- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us 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, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.
Limitation of Action
You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in Section 5: How to File a Claim.

You cannot bring any legal action against us for any other reasons until you have completed all the steps in the appeal process described in Section 6: Questions, Complaints and Appeals. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy
The Policy issued to the Enrolling Group, including this Certificate, the Schedule of Benefits, the Enrolling Group's application, and any Riders and/or Amendments, constitutes the entire Policy.
Section 9: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency health services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.
- Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of eligible expenses you must pay per year for any combination of Covered Behavioral Health Services under the Policy and covered medical services described in the Enrolling Group's medical plan documents before we will begin paying for Benefits. The amount that is applied to the Annual Deductible for Covered Behavioral Health Services is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the Schedule of Benefits to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Autism Spectrum Disorders - a group of neurobiological disorders that includes Autistic Disorder, Rett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDD NOS).

Benefits - your right to payment for Covered Behavioral Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this Certificate, the Schedule of Benefits, and any attached Riders and/or Amendments.

Clinician - any of the following behavioral health providers who is properly qualified by law and duly licensed or certified by the state in which he or she is located to provide Mental Health Services and Substance Use Disorder Services:

- Physician.
- Psychologist.
- Masters Level licensed clinician.

Please Note: Any clinical social worker, marriage, family and child counselor, or mental health clinical nurse specialist or other provider who acts within the scope of his or her license will be considered on the same basis as a Clinician.

The fact that we describe a provider as a Clinician does not mean that Benefits for services from that provider are available to you under the Policy. See Section 1: Covered Behavioral Health Services under Benefits for Covered Behavioral Health Services for more information.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Behavioral Health Services.

An acceptable lapse in coverage extends to 180 days under certain conditions. Credit for the time a person is covered under Continuous Creditable Coverage will be given if prior coverage stops for one of the following reasons and the person becomes eligible for coverage under the Policy within 180 days of the date prior coverage ends:

- Employment ends.
- Coverage available through employment or sponsored by an employer terminates.
An employer’s contribution toward health coverage terminates.

**Copayment** - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Behavioral Health Services.

Please note that for Covered Behavioral Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

**Covered Behavioral Health Service(s)** - those Mental Health Services and Substance Use Disorder Services which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing, or treating a Mental Illness, substance use disorder, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Clinician, facility or any other person.
- Described as a Covered Behavioral Health Service in this Certificate under Section 1: Covered Behavioral Health Services and in the Schedule of Benefits.
- Determined to be Medically Necessary.
- Pre-certified by UBH as required in the Schedule of Benefits or otherwise authorized as part of UBH's Utilization Review process.
- Not otherwise excluded in this Certificate under Section 2: Exclusions and Limitations.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Covered Persons, by calling Customer Service at the telephone number on your ID card, and to Clinicians.

**Covered Person** - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this Certificate are references to a Covered Person.

**Custodial Care** - services that provide a protected, controlled environment for the primary purpose of protective care 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.

**Dependent** - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber’s spouse.

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
  A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age 26.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

Enrollment may not be denied based on any of the following facts:

- The child does not reside with the Subscriber.
- The child is born out of wedlock.
- The child is not claimed as a dependent on the Subscriber’s federal or state income tax.
- The child lives outside the service area.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

**Domestic Partnership** - a person who meets the eligibility requirements, as defined by the Enrolling Group, and the following:

- Is eighteen (18) years of age or older.
- Is mentally competent to consent to contract.
- Has a common residence with the Subscriber.
- Is unmarried or not a member of another domestic partnership.
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

A Domestic Partnership will be established when both persons file a Declaration of Domestic Partnership with the Secretary of State.

**Eligible Expenses** - for Covered Behavioral Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the Schedule of Benefits.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
• As used for Medicare.
• As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

**Eligible Person** - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside within the United States.

**Emergency** - a serious mental health or substance use disorder, condition or symptom which is both of the following:

• Arises suddenly.
• In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

**Emergency Behavioral Health Services** - health care services and supplies necessary for the treatment of an Emergency.

**Enrolled Dependent** - a Dependent who is properly enrolled under the Policy.

**Enrolling Group** - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

**Experimental or Investigational Service(s)** - psychiatric, mental health, substance use disorder or other behavioral health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

• Not approved by the *U.S. Food and Drug Administration* (FDA) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.

• Subject to review and approval by any institutional review board for the proposed use.

• The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

**Exceptions:**

• Life-Threatening Sickness or Condition. If you have a life-threatening behavioral health sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Behavioral Health Service for that sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition.

**Hospital** - an institution that is operated as required by law and that is primarily engaged in providing, on an inpatient basis and at the patient's expense, health services for the acute care and treatment of injured or sick individuals and that fully meets one of the following three requirements:

• Is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.
• Is approved by Medicare as a hospital.
• Meets all of the following:
  ▪ Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of duly qualified Physicians.
  ▪ Has 24-hour nursing services.
  ▪ Is operated continuously with organized facilities for operative surgery on the premises.
A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

**Initial Enrollment Period** - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

**Inpatient Detoxification** - services that are provided in an acute care Hospital or other licensed facility for the purpose of completing a medically safe withdrawal from substances.

**Inpatient Stay** - an uninterrupted confinement that follows formal admission to a Hospital.

**Intensive Outpatient Treatment** - a structured outpatient Mental Health Services or Substance Use Disorder Services treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

**Intermediate Care** - Mental Health or Substance Use Disorder treatment that encompasses or meets one of the following:

- Care at a Residential Treatment Facility.
- Care at a Partial Hospital/Day Treatment program.

**Late Enrollee** - an Eligible Person or Dependent who enrolls for coverage under the Policy at a time other than the following:

- During the Initial Enrollment Period.
- During an Open Enrollment Period.
- During a special enrollment period as described in Section 3: When Coverage Begins.
- Within 31 days of the date a new Eligible Person first becomes eligible.

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

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

**Medicare** - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

**Mental Health Services** - Covered Behavioral Health Services for the diagnosis and treatment of Mental Illnesses that are 1.) treated primarily with psychotherapy or other psychotherapeutic methods; and 2.) listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Behavioral Health Service.

**Mental Illness** - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.
Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Behavioral Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Behavioral Health Services, but not all Covered Behavioral Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Behavioral Health Services and products included in the participation agreement, and a non-Network provider for other Covered Behavioral Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Behavioral Health Services provided by Network Clinicians or other Network providers. Refer to the Schedule of Benefits to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Behavioral Health Services provided by non-Network Clinicians or other non-Network providers. Refer to the Schedule of Benefits to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the Schedule of Benefits to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Physician - any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The Group Policy.
- This Certificate.
- The Schedule of Benefits.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Psychologist - a person who has a doctoral or other terminal degree in psychology from an organized, sequential program in a regionally accredited university or professional school and who is licensed and authorized by the state to practice as a professional psychologist.
Residential Treatment Facility - A facility which provides a program of effective Mental Health Services and/or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by us.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital for purposes of the Policy, including this Certificate and the Schedule of Benefits.

Rider - any attached written description of additional Covered Behavioral Health Services not described in this Certificate. Covered Behavioral Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Behavioral Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Substance Use Disorder Services - Covered Behavioral Health Services for the diagnosis and treatment of alcoholism and substance use disorders, including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause, that are 1.) treated primarily with psychotherapy or other psychotherapeutic methods; and 2.) listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded.

Detoxification services given prior to and independent of a course of psychotherapy or substance use disorder treatment are not considered Substance Use Disorder Services.

The fact that a disorder is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Behavioral Health Service.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Care - Mental Health/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an
adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

**Unproven Service(s)** - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain behavioral health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice.

Please note:

- If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Behavioral Health Service for that sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition.

- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Behavioral Health Service for a Covered Person with a sickness or injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
  - The service must be available from a Network Clinician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Behavioral Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

**Utilization Review** - a pre-service, concurrent (ongoing) or post-service review and determination by UBH as to whether services and/or supplies are Covered Behavioral Health Services.
Section 10: Schedule of Benefits

Accessing Benefits
You can choose to receive Network Benefits or Non-Network Benefits.

**Network Benefits** apply to Covered Behavioral Health Services that are provided by a Network Clinician or other Network provider. For facility services, these are Benefits for Covered Behavioral Health Services that are provided at a Network facility. Emergency Behavioral Health Services are always paid as Network Benefits.

**Non-Network Benefits** apply to Covered Behavioral Health Services that are provided by a non-Network Clinician or other non-Network provider, or Covered Behavioral Health Services that are provided at a non-Network facility.

**Network Benefits** are generally paid at a higher level of Benefits than are **Non-Network Benefits**.

United Behavioral Health (UBH) administers all Benefits described in this **Schedule of Benefits**, the **Certificate**, and any Riders and/or Amendments.

Depending on the geographic area and the service you receive, you may have access to non-Network providers who have agreed to discount their charges for Covered Behavioral Health Services. If you receive Covered Behavioral Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Behavioral Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less because the Eligible Expense may be a lesser amount.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Insurance Company Policy. As a result, they may bill you for the entire cost of the services you receive.

**Additional information about the network of providers and how your Benefits may be affected appears at the end of this Schedule of Benefits.**

If there is a conflict between this **Schedule of Benefits** and any summaries provided to you by the Enrolling Group, this **Schedule of Benefits** will control.

Utilization Review

**Utilization Review**

To receive the highest level of Benefits under this Benefit plan you, or your Network Clinician when applicable, must call United Behavioral Health (UBH) before obtaining services. **The toll-free number is 1-800-888-2998. UBH is ready to take your call 7 days a week, 24 hours a day.** This call starts the Utilization Review process.

The Utilization Review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. When you call UBH as required by this section, you will be given the names of Network Clinicians who are experienced in addressing your specific problems or concerns. If you are not satisfied with a Network Clinician, you may call UBH and ask for a referral to another Network Clinician.

UBH performs Utilization Review to determine whether the requested service is a Covered Behavioral Health Service. UBH does not make treatment decisions about the kind of behavioral health care you should or should not receive. You and your Clinician must make those treatment decisions. We have the responsibility to make factual determinations relating to Benefits and to interpret Benefits and the other...
terms, limitations and exclusions set out in the Certificate, this Schedule of Benefits, and any Riders and/or Amendments.

**Services from Non-Network Clinicians**

When you choose to receive services from non-Network Clinicians, we urge you to confirm with us that the services you plan to receive are Covered Behavioral Health Services and to ensure that you will receive the highest level of Benefits available to you. In some instances, certain procedures may not meet the definition of a Covered Behavioral Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Behavioral Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

**Benefit Determinations**

**Benefit Requests for Pre-Certified Treatment**

For services that require pre-certification prior to receiving treatment, if your request was submitted properly with all needed information, you will receive written notice of the decision from UBH within 15 days of receipt of the request for pre-certification. If your request is submitted incorrectly, UBH will notify you of the incorrect filing and how to correct it within five days after receipt of your request for pre-certified treatment. If additional information is needed to process the request for pre-certified treatment, UBH will notify you of the information needed within 15 days after receipt of your request, and may request a one-time extension not longer than 15 days, pending your request until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all the needed information is received within the 45-day time frame, UBH will notify you of the determination within 15 days after receipt of the information. If you do not provide the needed information within the 45-day period, the request will be denied. A denial notice will explain the reason for denial, refer to the part of the Policy on which the denial is based, and provide you with appeal procedures.

**Benefit Requests for Continuing Treatment**

If an ongoing course of treatment was previously certified for a specific period of time or number of treatments, and the request to extend the treatment is “urgent” as defined below, your request will be decided within 24 hours, provided the request is made at least 24 hours prior to the end of the certified treatment. If the request for extended treatment is not made at least 24 hours prior to the end of the certified treatment, the request will be treated as “urgent” and decided according to the timeframes described below.

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

**Benefit Requests for Post-Service Claims**

Post-service claims are those claims that are filed for payment of Benefits after services have been received. If your post-service claim is denied, you will receive a written notice from UBH within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UBH will notify you 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, pending the claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all the needed information is received within the 45-day time frame, and the claim is denied, UBH will notify you of the denial within 15 days after receipt of the information. If you do not provide the needed information within the 45-day period, your claim will be denied.
Urgent Situations that Require Immediate Attention

Urgent requests for pre-certification are those urgent requests that require pre-certification or a benefit determination prior to receiving treatment. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 24 hours after UBH receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If you file an urgent request improperly, UBH will notify you of the improper filing and how to correct it within 24 hours after receipt of the request. If additional information is needed to process the request, UBH will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- UBH’s receipt of the requested information; or
- The end of the 48-hour period which you were 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 Policy on which the denial is based, and provide you with appeal procedures.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the pre-certification requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in Section 7: Coordination of Benefits. In this instance, you are not required to contact us before receiving Covered Behavioral Health Services.

Benefits

Out-of-Pocket Maximums are calculated on a calendar year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.
NOTE: To ensure that you receive the maximum benefits available under the plan, you should contact UBH prior to receiving care at 1-800-888-2998. If the services are rendered as the result of an Emergency, you should contact UBH as soon as possible after care has been rendered.

Schedule of Benefits

<table>
<thead>
<tr>
<th>Comprehensive Plan Enrollees</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles and Copayments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>$200 Individual</td>
<td>$400 Individual</td>
</tr>
<tr>
<td></td>
<td>$600 Family</td>
<td>$1200 Family</td>
</tr>
<tr>
<td>Copayment</td>
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<td>$200 Copay</td>
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Percentage Payable after Deductibles/Copayments Satisfied

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<thead>
<tr>
<th></th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Substance Abuse Inpatient</td>
<td>Plan pays 90%</td>
<td>Plan pays 70% After Copay</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse Outpatient</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$1,500 per Person</td>
<td>$3,000 per Person</td>
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<tr>
<td></td>
<td>$3,000 per Family</td>
<td>$6,000 per Family</td>
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<tr>
<td>Annual Maximum</td>
<td>Unlimited</td>
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</table>

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

<table>
<thead>
<tr>
<th>Graduate Student Enrollees</th>
<th>Network</th>
<th>Non-Network</th>
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<tbody>
<tr>
<td>Deductibles and Copayments</td>
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</tr>
<tr>
<td>Deductible</td>
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<td>$200 Individual</td>
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<td></td>
<td></td>
<td>$400 Family</td>
</tr>
<tr>
<td>Copayment</td>
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<td>$200 Copay</td>
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</table>

Percentage Payable after Deductibles/Copayments Satisfied

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Substance Abuse Inpatient</td>
<td>Plan pays 100%</td>
<td>Plan pays 70% After Copay</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse Outpatient</td>
<td>Plan pays 100%</td>
<td>Plan pays 70%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>Unlimited</td>
<td>$2,000 per Person</td>
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<tr>
<td></td>
<td></td>
<td>$6,000 per Family</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>Unlimited</td>
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All benefits are paid in accordance with the Reasonable Charge. Refer to the Glossary for the definition of Reasonable Charge.
<table>
<thead>
<tr>
<th>Catastrophic Plan Enrollees</th>
<th>Network</th>
<th>Non-Network</th>
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</thead>
<tbody>
<tr>
<td><strong>Deductibles and Copayments</strong></td>
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<td></td>
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<tr>
<td>Deductible</td>
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<td>$6,000 Family</td>
<td>$6,000 Family</td>
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<tr>
<td>Copayment</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Percentage Payable after Deductibles/Copayments Satisfied</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health and Substance Abuse Inpatient</td>
<td>Plan pays 80%</td>
<td>Plan pays 80%</td>
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<tr>
<td>Mental Health and Substance Abuse Outpatient</td>
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<tr>
<td>Out-of-Pocket Maximum</td>
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<td>$5,000 per Person</td>
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<tr>
<td></td>
<td>$10,000 per Family</td>
<td>$10,000 per Family</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

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

**Eligible Expenses**

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the Certificate.

For Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Behavioral Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Behavioral Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

**Provider Network**

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers’ licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider and obtain pre-certification as applicable. A provider’s status may change. You can verify the provider’s status by calling Customer Service. A directory of providers is available by calling Customer Service at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.
If you are currently undergoing a course of treatment utilizing a non-Network Clinician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact Customer Service at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Behavioral Health Services. Some Network providers contract with us to provide only certain Covered Behavioral Health Services, but not all Covered Behavioral Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Behavioral Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Behavioral Health Services are received from non-Network providers. In this situation you, or your Network Clinician if available, will notify UBH and, if UBH confirms that care is not available from a Network provider, UBH will work with you, or your Network Clinician when available, to coordinate care through a non-Network provider.