U.S. Behavioral Health Plan, California*

Combined Evidence of Coverage and Disclosure Form HMO

Behavioral Health Plan

Effective July 1, 2019

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

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INTRODUCTION

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

U.S. Behavioral Health Plan, California (USBHPC) provides **Mental Disorder and Substance-Related and Addictive Disorder** coverage. This coverage includes the treatment of Severe Mental Illness (SMI) for persons of any age and treatment for children under the age of 18 with Serious Emotional Disturbance (SED). As a USBHPC Member, you and your eligible Dependent always have direct, around-the-clock access to behavioral health benefits. You do not need to go through a Primary Care Physician (PCP) to access your behavioral health benefits, and all services are completely confidential.

This *Combined Evidence of Coverage and Disclosure Form* will help you become more familiar with your Behavioral Health Care benefits. It is a legal document that explains your Behavioral Health Plan and should answer many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see **Section 10. Definitions.**

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

What else should I read to understand my benefits?

Along with this Combined Evidence of Coverage and Disclosure Form, be sure to review your USBHPC Schedule of Benefits in this Combined Evidence of Coverage and Disclosure Form for details of your particular Behavioral Health Plan, including any Co-payments or co-insurance that you may have to pay when accessing Behavioral Health Services. Together, these documents explain your coverage.

What if I still need help?

After you become familiar with your behavioral health benefits, you may still need assistance. Please do not hesitate to call our Customer Service Department at 1-877-449-6710, or for the hearing and speech impaired dial 711 and at the operator's request, say or enter 1-877-449-6710.

You may write to USBHPC at the following address:

U.S. Behavioral Health Plan, California
425 Market Street, 14th Floor
San Francisco, CA 94105
Or visit USBHPC's Web site:
www.liveandworkwell.com

SECTION 1. UNDERSTANDING BEHAVIORAL HEALTH: YOUR BENEFITS

- **What are Behavioral Health Services?**
- **What is a Mental Disorder?**
- **What is a Severe Mental Illness?**
- **What is the Serious Emotional Disturbance of a Child?**
- **What does USBHPC do?**

This Section helps you understand what behavioral health services are and provides a general understanding of some of the services U.S. Behavioral Health Plan, California (USBHPC) provides.

What are Behavioral Health Services?

Behavioral Health Services are those services provided or arranged by USBHPC for the Medically Necessary treatment of:

- Mental Disorders, including but not limited to treatment for the Severe Mental Illness of an adult or child and/or the Serious Emotional Disturbance of a Child, and/or
- Alcohol and drug problems, also known as **Substance-Related and Addictive Disorder**, substance use, substance abuse or chemical dependency.

What is a Mental Disorder?

A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

Any mental health condition identified as a Mental Disorder in the DSM is covered. USBHPC does not cover services for conditions that the DSM identifies as something other than a “mental disorder” such as relational problems, e.g. couples counseling or family counseling.

Mental Disorders also include a Severe Mental Illness of a Person of Any Age (“Severe Mental Illness” or “SMI”) or a Serious Emotional Disturbance of a Child under the Age of 18 (“Serious Emotional Disturbance of a Child” or “SED”) as defined in the most recent edition of the *DSM*.

What is a Severe Mental Illness?

A Severe Mental Illness (SMI) of a person of any age means the following Mental Disorders:

- Anorexia Nervosa
- Bipolar Disorder (manic-depressive illness)
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder or autism, including Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism.
- Schizoaffective Disorder
- Schizophrenia

What is a Serious Emotional Disturbance of a Child?

A Serious Emotional Disturbance (SED) of a Child under age 18 means a condition identified as a Mental Disorder in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), other than a primary substance

use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms if the child also meets at least one of the following three criteria:

a. As a result of the Mental Disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and (2) either

   i. child is at risk of removal from home or has already been removed from the home; or

   ii. Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

b. The child displays psychotic features, risk of suicide or risk of violence due to a Mental Disorder; or

c. The child has been assessed pursuant to Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code and determined to have an emotional disturbance, as defined in paragraph (4) of subdivision (c) of Section 300.8 of Title 34 of the Code of Federal Regulations.

What does U.S. Behavioral Health Plan, California do?

USBHPC arranges for the provision of Behavioral Health Services to our Members.

- You have direct 24-hour phone access to our services.
- Your Medically Necessary Behavioral Health Services are coordinated and paid for as provided under your Behavioral Health Plan, so long as you use USBHPC Participating Providers.
- You may be responsible for payment of some Co-payments or Co-insurance amounts for covered services provided in-person or telehealth modality, as set forth in the attached *Schedule of Benefits*. The Co-payment or Co-insurance are the same for a covered service provided either in-person or telehealth modality.

All services covered under this Behavioral Health Plan will be provided by a USBHPC Participating Provider except in the case of an Emergency. Pre-Authorization is required for certain Mental Health Services and Substance-Related and Addictive Disorder Services. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through USBHPC for Inpatient services, Residential Treatment services, Intensive Outpatient Treatment, Outpatient Electro-Convulsive Treatment, Partial Hospitalization/ Day Treatment, Behavioral Health Treatment for PDD/ Autism including Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention programs, Medical Detoxification, Methadone Maintenance Treatment and Psychological Testing when necessary to diagnose and evaluate a Mental Disorder, except in the event of an Emergency. If you have questions about your benefits, simply call the USBHPC Customer Service Department at 1-877-449-6710 at any time. Our staff is always there to assist you 24 hours a day, with understanding your benefits, authorizing services, helping you select a Provider, or anything else related to your USBHPC Behavioral Health Plan.

Your USBHPC Behavioral Health Plan provides coverage for the Medically Necessary treatment of Mental Disorders and **Substance-Related and Addictive Disorder** on both an inpatient and outpatient basis. Details concerning your behavioral health benefits can be found in your *Schedule of Benefits* and in **Section 4** of this *Combined Evidence of Coverage and Disclosure Form*.

SECTION 2. GETTING STARTED: YOUR PARTICIPATING PROVIDER

- **Do I need a referral?**
- **How do I access Behavioral Health Services?**
- **Timely Access to Care**
- **Choice of Physicians and Providers**
- **Continuity of Care**

This Section explains how to obtain USBHPC Behavioral Health Services and the role of USBHPC's Participating Providers.

How do I access Behavioral Health Services?

Step 1

To access Behavioral Health Services, you should contact USBHPC first, except in an Emergency. You may either visit USBHPC's Website at www.liveandworkwell.com to find a Participating Provider or call USBHPC Customer Service at 1-877-449-6710. Some Behavioral Health Services may be available via telehealth modality in addition to receiving services in-person from a Participating Provider. You may find a Participating Provider offering services via telehealth modality either at USBHPC's Website at www.liveandworkwell.com or by calling USBHPC Customer Service at 1-877-449-6710. When you call USBHPC Customer Service, a USBHPC staff member will make sure you are an eligible Member of the USBHPC Behavioral Health Plan and answer any questions you may have about your benefits. The USBHPC staff member will conduct a brief telephone screening by asking you questions, such as:

- What are the problems or symptoms you are having?
- Are you already seeing a Provider?
- What kind of Provider do you prefer?

You will then be given the name and telephone numbers of one or more USBHPC Participating Providers near your home or work that meets your needs.

Step 2

You call the USBHPC Participating Provider's office to make an appointment. If your request for services is non-urgent, the Participating provider is expected to offer you an appointment within ten (10) working days. See Timely Access to Care section for additional information.

Step 3

You do not need prior approval for routine outpatient services. However, all inpatient services and residential treatment services must be pre-authorized. Also, certain non-routine outpatient services that you receive from your USBHPC Participating Provider may need pre-authorization from USBHPC, except in the event of an Emergency. Non-routine outpatient services are: Intensive Outpatient Treatment; Outpatient Electro-Convulsive Treatment; Partial Hospitalization/ Day Treatment, Behavioral Health Treatment for PDD/ Autism including Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention programs; Medical Detoxification; Methadone Maintenance Treatment; and Psychological Testing when necessary to diagnose and evaluate a Mental Disorder, except in the event of an Emergency. After your first Visit, your USBHPC Participating Provider will get any necessary approval from USBHPC before you receive these services. Such services must be provided at the office of the Participating Practitioner or at a participating Outpatient Treatment Center.

Information on Telehealth

Some Behavioral Health and Substance-Related and Addictive Disorder Services may be available via telehealth modality. Telehealth services are optional, and you can choose whether you prefer to receive behavioral health services via telehealth modality or in-person. When a Participating Provider has a physical office location and also offers telehealth modality, you

may choose the modality in which you receive behavioral health services in agreement with the provider. Instructions on how to access and utilize telehealth services are provided to you by the Participating Provider utilizing telehealth modality to deliver behavioral health services.

Timely Access to Care

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

Standard	Criteria	Time Frame for Appointment
Non-Life-Threatening Emergency	A situation in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm to self or others	Members must be offered an appointment within 6 hours of the request for the appointment
Urgent	A situation in which immediate care is not needed for stabilization but, if not addressed in a timely way, could escalate to an emergency situation	Members must be offered an appointment within 48 hours of the request for the appointment
Routine (non-urgent)	A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others	Members must be offered an appointment within 10 business days of the request for the appointment

Telephone wait times:

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

Please note:

The time for a particular, non-emergency appointment may be extended if it is determined[1] and documented that a longer waiting time will not have a detrimental impact on the Member's health. Rescheduling of appointments, when necessary, must be consistent with good professional care and ensure there is no detriment to the Member.

Additional Information:

- USBHPC expects all Participating Providers to return calls to Members within 24 hours.
- Interpreter services are available to Members at the time of the appointment if requested by the Member or provider. To request interpreter services contact us at 1-877-449-6710. Language interpretation services are available at no cost to the Member.

USBHPC is committed to offering clinically appropriate and timely access to care pursuant to Section 1367.031 of the California Health and Safety Code. If you are unable to obtain a timely referral to an appropriate provider, you may contact USBHPC for assistance by calling 1-877-449-6710. Additionally, the DMHC Help Center may be contacted at 1-888-466-2219 to file a complaint if you are unable to obtain a timely referral to an appropriate Participating Provider.

[1] An extension to the time for a non-emergency appointment may be determined by the referring or treating licensed health care provider or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and is consistent with professionally recognized standards of practice.

Important Language Information:

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

You can get an interpreter in any of the top 15 languages spoken by limited English-proficient individuals at no cost to help you talk with your provider or health plan. USBHPC uses a telephone translation service for almost 140 languages and dialects. In addition to Customer Service representatives who are fluent in Spanish, translated Member materials are available upon request. Interpretation services are available at no charge to the member in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services. To get help in your language, please call your health plan at: U.S. Behavioral Health Plan, California at 1-877-449-6710/ TTY: 711.

Language services and the availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, will be at no charge and provided in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities. For further assistance, please contact USBHPC at 1-877-449-6710.

If you need more help, call HMO Help Line at 1-888-466-2219.

Choice of Physicians and Providers

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

Call the USBHPC Customer Service Department for:

- Information on USBHPC Participating Providers,

Provider office hours,

- Background information such as their areas of specialization,
- A copy of our, or access to *Provider Directory*.

Facilities

Along with listing our Participating Providers, your USBHPC Participating Provider Directory has detailed information about our Participating Providers. If you need a copy or would like assistance picking your Participating Provider, please call our Customer Service Department. You can also find an online version of the USBHPC Participating Provider Directory at **www.liveandworkwell.com**.

What if I want to change my Participating Provider?

Simply call the USBHPC Customer Service toll-free number at 1-877-449-6710 to select another USBHPC Participating Provider.

If I see a Provider who is not part of USBHPC's Provider Network, will it cost me more?

Yes. If you are enrolled in this USBHPC Behavioral Health Plan and choose to see a Provider who is not part of the USBHPC network, the services will be excluded; and you will have to pay for the entire cost of the treatment (except in an Emergency) with no reimbursement from USBHPC.

Can I call USBHPC in the evening or on weekends?

Yes. If you need services after normal business hours, please call USBHPC's Customer Service Department at 1 1-877-449-6710. For the hearing and speech impaired, dial 711 and at the operator's request, enter 1-877-449-6710. A staff member is always there to help.

Continuity of Care with a Terminated Provider

In the event your Participating Provider is no longer a part of the USBHPC Provider network for reasons other than a medical disciplinary cause or reason, fraud or other criminal activity, you may be eligible to continue receiving care from that Provider to ensure a smooth transition to a new Participating Provider and to complete a course of treatment with the same terminated Provider.

For a Member to continue receiving care from a terminated Provider, the following conditions must be met:

1. Continuity of Care services from a terminated Provider must be preauthorized by USBHPC;
2. The requested treatment must be a Covered Service under this Plan;
3. The terminated Provider must agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements, notwithstanding the provisions outlined in the Provider contract related to Continuity of Care;
4. The terminated Provider must agree in writing to be compensated at rates and methods of payment similar to those used by USBHPC for current Participating Providers providing similar services who are practicing in the same or a similar geographic area as the terminated Provider.

Covered Services for the Continuity of Care Condition under treatment by the Terminated or Non-Participating Mental Health Provider will be considered complete when:

a. The Member's Continuity of Care Condition under treatment is medically stable, and
b. There are no clinical contraindications that would prevent a medically safe transfer to a Participating Mental Health Provider as determined by a USBHPC Medical Director (or designee) in consultation with the Member, the Terminated Mental Health Provider and, as applicable, the Member's receiving Participating Provider.

All Continuity of Care requests will be reviewed on a case-by-case basis. Reasonable consideration will be given to the severity of the Member's condition and the potential clinical effect of a change in Provider regarding the Member's treatment and outcome of the condition under treatment.

If you are receiving treatment for any of the specified Continuity of Care Conditions as limited and described in **Section 10. Definitions**, and believe you qualify for continued care with the terminating Provider, please call the Customer Service Department and request the form "Request for Continuity of Care." Complete and return the form to USBHPC as soon as possible, but within thirty (30) calendar days of the Provider effective date of termination.

If you have any questions about this provision or would like a copy of our Continuity of Care Policy, you may call our Customer Service Department.

Continuity of Care for New Members

Under certain circumstances, new Members of USBHPC may be able to temporarily continue receiving services from a Non-Participating Provider. This short-term transition assistance may be available for a new Member who, at the time his or her coverage became effective, was receiving services from that provider as described below:

1. Did not have the option to continue with his/her previous behavioral health plan at time of enrollment;
2 Is receiving treatment that is a benefit under this USBHPC Benefit Plan; and
3. Was not offered a plan with an out-of-network option.

Covered Services will be provided by a Non-Participating Provider as identified below to a Member who at time of enrollment was receiving any of the following Covered Services from a Non-Participating Provider:

1. An Acute Condition: An acute condition is a behavioral health condition that involves a sudden onset of symptoms due to an illness, or other behavioral health problems that requires prompt medical attention and that has a limited duration. USBHPC shall provide covered behavioral health services with the Non-Participating Provider for the duration of the acute condition when the newly covered enrollee is under treatment by the Non-Participating Provider at the time his or her coverage became effective under the Plan.

2. A Serious Chronic Condition: A serious chronic condition is a behavioral health condition due to illness or other behavioral health conditions that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time necessary to complete the course of treatment at the time his or her coverage became effective and to arrange for a clinically safe transfer to a Participating Provider, as determined by the USBHPC Medical Director (or designee) in consultation with the Member, the Non-Participating Provider and as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed twelve (12) months from the effective date of coverage for the newly covered enrollee.
3. Maternal Mental Health Condition: A "maternal mental health condition" is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery. Covered Services will be provided for an individual who presents written documentation of being diagnosed with a "maternal mental health condition" from the individual's treating health care provider for a period not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
4. Other Procedure: Other procedure that has been authorized by USBHPC as part of a documented course of treatment and had been recommended and documented by the Non-Participating Provider to occur within 180 calendar days of the effective date of coverage for the newly covered enrollee for the completion of the procedure..

Behavioral Health Services provided by a Non-Participating Provider may be covered by USBHPC for the purpose of safely transitioning you or your Dependent to a USBHPC Participating Provider. If the Behavioral Health Services are preauthorized by USBHPC, USBHPC may cover such services to the extent they would be covered if provided by a USBHPC Participating Provider under the USBHPC Behavioral Health Plan. This means that you will only be responsible for your Co-payment or co-insurance listed on the *Schedule of Benefits*. The Non-Participating Provider must agree in writing to the same contractual terms and conditions that are imposed upon USBHPC Participating Providers, including reimbursement methodologies and rates of payment. If the non-participating provider does not agree to comply with these contractual terms and conditions, USBHPC is not required to continue the non-participating provider's services. **These Continuity of Care services, except for Emergency Services, must be approved by USBHPC**. If you would like to request continuing treatment from a Non-Participating Provider, call the USBHPC Customer Service Department within 30 days of the effective date of coverage. If you have any questions or would like a copy of USBHPC's continuity-of-care policy, call or write the USBHPC Customer Service Department.

SECTION 3. EMERGENCY SERVICES AND URGENTLY NEEDED SERVICES

- **What is an Emergency?**
- **What are Psychiatric Emergency Services?**
- **What To Do When You Require Psychiatric Emergency Services**
- **What To Do When You Require Urgently Needed Services**
- **Continuing or Follow-Up of Emergency Treatment**
- **If I am out of State or traveling, am I still covered?**

Worldwide, wherever you are, USBHPC provides coverage for Emergency Services and Urgently Needed Services. This section will explain how to obtain Emergency Services and Urgently Needed Services. It will also explain what you should do following receipt of these services

IMPORTANT!

If you believe you are experiencing an Emergency condition, call 911 or go directly to the nearest hospital emergency room or other facility for treatment.

What is an Emergency?

An Emergency is defined as a condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate Behavioral Health Services could reasonably be expected by the Member to result in any of the following:

- Immediate harm to self or others;
- Placing your health in serious jeopardy;
- Serious impairment of your functioning; or
- Serious dysfunction of any bodily organ or part.

A situation will be considered an Emergency if you or your Dependent are experiencing a situation which, absent immediate medical attention, could reasonably be expected to result in serious deterioration to your mental health.

An Emergency Medical Condition also includes a Psychiatric Emergency Medical Condition which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

1. An immediate danger to himself or herself or others; or
2. Immediately unable to provide for, or utilize, food, shelter or clothing, due to the mental disorder.

What are Psychiatric Emergency Services?

Psychiatric Emergency Services are Medically Necessary ambulance or ambulance transport services provided through the 911 Emergency response system. It also includes the medical screening, examination and evaluation by a Physician, or other licensed personnel – to the extent provided by law – to determine if a Psychiatric Emergency exists. If a Psychiatric Emergency condition exists, Psychiatric Emergency Services include the care and treatment necessary to relieve or eliminate the Emergency condition within the capabilities of the facility which includes admission or transfer to a psychiatric unit within a general acute hospital or acute psychiatric hospital for the purpose of providing care and treatment necessary to relieve or eliminate Psychiatric Emergency Medical Condition, if in the opinion of the treating provider it would not result in material deterioration of the Member's condition.

What To Do When You Require Psychiatric Emergency Services

Step 1: In an Emergency, get help or treatment immediately.

This means you should call 911 or go directly to the nearest medical facility for treatment.

Step 2: Then, within 48 hours of your Emergency, or as soon as is reasonably possible after your condition is stable, you, or someone acting on your behalf, must call USBHPC at 1-877-449-6710.

This is important.

Psychiatric Emergency Services are covered only as long as the condition continues to be an Emergency. Once the condition is under control and you can be safely transferred or discharged, additional charges incurred through the Emergency care facility will not be covered.

Step 3: USBHPC will arrange follow up services for your condition after an Emergency. USBHPC may move you to a Participating Provider in our network, as long as the move would not harm your health.

It is appropriate for you to use the 911 Emergency response system, or alternative Emergency system in your area, for assistance in an Emergency situation when ambulance transport services are required and you reasonably believe that your condition is immediate, serious and requires Emergency transport services to take you to the appropriate facility.

What To Do When You Require Urgently Needed Services

In-Area Urgently Needed Services

If you need Urgently Needed Services when you are in the Service Area, you should contact your Participating Provider. If you are calling during non-business hours, and your Participating Provider is not immediately available, call USBHPC Customer Service Department for assistance in finding a provider near your area. If your Participating Provider or USBHPC

is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a Participating or Non-Participating licensed behavioral health professional, wherever you are located.

Out-of-Area Urgently Needed Services

Urgently Needed Services are required in situations where a Member is temporarily outside the Service Area and the Member experiences a mental condition that, while less serious than an Emergency, could result in the serious deterioration of the Member's mental health if not treated before the Member returns to the Service Area.

When you are temporarily outside the Service Area, and you believe that you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your Participating Provider. If you are calling during nonbusiness hours, and your Provider is not immediately available, call USBHPC Customer Service Department for assistance in finding a Provider near your area. If your Participating Provider or USBHPC is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a Participating or Non-Participating licensed behavioral health professional wherever you are located.

You, or someone else on your behalf, must notify USBHPC or your Participating Provider within 24 hours, or as soon as reasonably possible, after the initial receipt of Urgently Needed Services.

It is very important that you follow the steps outlined above. If you do not, you may be financially responsible for services received.

Continuing or Follow-up of Emergency Treatment or Urgently Needed Services

If you require Behavioral Health Services following an Emergency or Urgently Needed Services and you desire that these services be covered, the Behavioral Health Services must be coordinated and authorized by USBHPC. In addition, if a transfer does not create an unreasonable risk to your health, USBHPC may require that you transfer to a USBHPC Participating Provider designated by USBHPC for any treatment following the Emergency or Urgently Needed Services.

Failure to transfer or to obtain approval from USBHPC for continued treatment may result in all further treatment being denied if the services were not Medically Necessary or did not meet the Emergency or Urgently Needed Services criteria outlined in this document.

If I am out of State or traveling, am I still covered?

Yes, but only in an Emergency or Urgent situation. If you think you are experiencing an Emergency or require Urgently Needed Services, get treatment immediately. Then, as soon as reasonably possible, call USBHPC Customer Service Department to ensure your Emergency Treatment or Urgently Needed Services are covered. **This is important**.

If you are traveling outside of the United States, you can reach USBHPC by calling 1-877-447-5915 for additional instructions on what to do in the case of an Emergency or Urgent situation.

Note: Under certain circumstances, you may need to pay for your Emergency or Urgently Needed Services at the time of treatment. If this is necessary, please pay for such services and then contact USBHPC at the earliest opportunity. Be sure to keep all receipts and copies of relevant medical documentation. You will need these to be properly reimbursed. For more information on submitting claims to USBHPC, please refer to **Section 7. Overseeing Your Behavioral Health Decisions** in this *Combined Evidence of Coverage and Disclosure Form.*

SECTION 4. COVERED BEHAVIORAL HEALTH SERVICES

- **What Behavioral Health Services are covered?**
- **Exclusions and Limitations**

This section explains your Behavioral Health Benefits, including what is and is not covered by USBHPC. You can find some helpful definitions in the back of this publication. For any Co-payments either in-person or telehealth modality covered services that may be associated with a benefit, you need to refer to your Schedule of Benefits, a copy of which is included with this document.

What Behavioral Health Services are covered?

Behavioral Health Services are covered only when they are:

- Incurred while the Member is eligible for coverage under this Behavioral Health Plan;
- Medically Necessary;
- Pre-Authorized for certain Mental Health Services and Substance-Related and Addictive Disorder Services. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through USBHPC for Inpatient services, Residential Treatment services, Intensive Outpatient Treatment, Outpatient Electro-Convulsive Treatment, Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment, Behavioral Health Treatment for PDD/ Autism including Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention programs, Medical Detoxification, Methadone Maintenance Treatment and Psychological Testing, except in the event of an Emergency or Urgently Needed Service;
- Rendered by a USBHPC Participating Provider, except in the case of an Emergency or Urgently Needed Service; and
- Any mental health condition identified as a "mental disorder" in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. USBHPC does not cover services for conditions that the DSM identifies as something other than a "mental disorder" such as relational problems, e.g. couples counseling or family counseling. Mental Disorders also include a Severe Mental Illness of Person of Any Age ("SMI") or a Serious Emotional Disturbance of a Child under the Age of 18 ("SED"), as identified in the most recent edition of the DSM.

USBHPC will pay for the following Behavioral Health Services furnished in connection with the treatment of Mental Disorders and/or **Substance-Related and Addictive Disorders** as outlined in the *Schedule of Benefits*, provided the above criteria have been satisfied. You should refer to your *Schedule of Benefits* for further information about your particular Behavioral Health Plan.

Notwithstanding any exclusions or limitations described in this document, USHBPC will pay for all behavioral health services for a Member with a Severe Mental Illness of Person of any Age ("SMI") or Serious Emotional Disturbance of a Child under the Age of 18 ("SED") mental health condition as medically necessary.

I. Mental Health Services for the diagnosis and treatment of Mental Disorders including SMI and SED conditions, and Medically Necessary Behavioral Health Treatment administered by: Qualified Autism Service Providers Qualified Autism Service Professionals, or Qualified Autism Service Paraprofessionals as medically necessary**:**

A. **Inpatient**

1. **Inpatient Mental Health Services –** psychiatric inpatient services**,** including room and board, drugs and services, including psychiatric inpatient services from licensed mental health providers including but not limited to psychiatrists and psychologists, provided at an Inpatient Treatment Center, Residential Treatment Center are covered when Medically Necessary, preauthorized by USBHPC, and provided at a Participating Facility.
2. **Inpatient Physician Services** – Medically Necessary inpatient psychiatric services, including voluntary psychiatric inpatient services provided by a Participating Practitioner acting within the scope of their license while the Member is hospitalized as an inpatient at an Inpatient Treatment Center or is receiving services at a Participating Residential Treatment Center and which have been preauthorized by USBHPC.

B. **Outpatient**

1. **Outpatient Mental Health Services** – Medically Necessary Mental Health Services provided at the office of and/or via Telehealth by a Participating Practitioner including but not limited to; individual mental health evaluation and treatment, group mental health evaluation and treatment, and services for the purpose of monitoring drug therapy.

   Certain outpatient services that require preauthorization by USBHPC, when Medically Necessary are Outpatient Electro-Convulsive Treatment, Partial Hospitalization / Day Treatment and Intensive Outpatient Treatment, Behavioral Health Treatment for PDD / Autism including Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention programs; and Psychological Testing when necessary to diagnose and evaluate a Mental Disorder and authorized. Such services must be provided at the office of the Participating Practitioner or

at a Participating Outpatient Treatment Center. Intensive Psychiatric Treatment Programs may include Partial Hospitalization / Day Treatment Programs and Intensive Outpatient Treatment as intensive outpatient care.

2. **Behavioral Health Treatment for Pervasive Developmental Disorder ("PDD") or Autism –** Preauthorization required for Professional services and treatment programs, including applied behavioral analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Covered Person with pervasive developmental disorder, or autism, and that meet the criteria required by California law. Please refer to Section 10. Definitions, for a description of the required criteria.

3. **Intensive Psychiatric Treatment Programs –** when provided at a Participating Facility or Day Treatment Center, preauthorization is required. These programs include:

   - Short-term hospital-based intensive outpatient care (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)
   - Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
   - Short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis
   - Psychiatric observation for an acute psychiatric crisis

II. Substance-Related and Addictive Disorder Services

A. Inpatient

1. **Inpatient Substance-Related and Addictive Disorder Services, including Medical Detoxification provided at an Inpatient Treatment Center** – Medically Necessary **Substance-Related and Addictive Disorder** Services, including Medical Detoxification, which have been preauthorized by USBHPC and are provided by a Participating Practitioner while the Member is confined in a Participating Inpatient Treatment Center or at a Participating Residential Treatment Center

2. **Inpatient Physician Care** – Medically Necessary **Substance-Related and Addictive Disorder** Services, including Medical Detoxification, provided by a Participating Practitioner while the Member is confined at an Inpatient Treatment Center or at a Residential Treatment Center, or is receiving services at a Participating Day Treatment Center and which have been preauthorized by USBHPC.

3. **Medical Detoxification** – Medical Detoxification services, including room and board, drugs, dependency recovery services, education and counseling are covered when provided by a Participating Practitioner at a Participating Inpatient Treatment Center or at a Residential Treatment Center when preauthorized by USBHPC.

4. **Substance-Related and Addictive Disorder Services including Transitional Residential Recovery Services Rendered at a Residential Treatment Center** – Medically Necessary **Substance-Related and Addictive Disorder** Services, provided to a Member during confinement at a Participating Residential Treatment Center are covered, if provided or prescribed by a Participating Practitioner and preauthorized by USBHPC.

B. Outpatient

1. **Outpatient Substance-Related and Addictive Disorder Services -** Medically Necessary Substance-Related and Addictive Disorder services provided by a Participating Practitioner at a Participating Outpatient or Day Treatment Center and preauthorized, or at the office of a Participating Practitioner including Outpatient Evaluation and Treatment for Chemical Dependency:

   - day treatment programs including partial hospitalization
   - intensive outpatient programs
   - individual and group chemical dependency counseling, and
   - Medical treatment of withdrawal symptoms.

Medically Necessary Substance-Related and Addictive Disorder Services may be provided in the office and / or via Telehealth by a Participating Practitioner including but not limited to; individual and group chemical dependency counseling, and Medical treatment of withdrawal symptoms.

2. **Outpatient Physician Care** – Medically Necessary Substance-Related and Addictive Disorder Services provided by a Participating Practitioner, and preauthorized by USBHPC, e.g. Intensive Outpatient Treatment, and Partial Hospitalization/ Day Treatment. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient or Day Treatment Center.
3. **Methadone Maintenance Treatment** - Medically Necessary methadone maintenance treatment is covered when, preauthorized by USBHPC and provided at facilities licensed to provide such treatment.

III. Other Behavioral Health Services

1. **Ambulance** – Use of an ambulance (land or air) for Emergencies, including, but not limited to, ambulance or ambulance transport services provided through the 911 Emergency response systems is covered without prior authorization when the Member reasonably believes that the behavioral health condition requires Emergency Services that require ambulance transport services.

   Use of an ambulance or a psychiatric transport service for a non-Emergency is covered only when specifically authorized by USBHPC and if:

   - USBHPC or a Participating Practitioner determines the Member's condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide; and
   - The use of other means of transportation would endanger the Member's health.
   - These services are covered only when the vehicle transports the Member to or from covered services.
2. **Laboratory Services** – Diagnostic and therapeutic laboratory services are covered when ordered by a Participating Practitioner in connection with the Medically Necessary diagnosis and treatment of Mental Disorder and/or Substance-Related and Addictive Disorder**.**
3. **Inpatient Prescription Drugs** – Inpatient prescription drugs are covered only when prescribed by a USBHPC Participating Practitioner for treatment of a Mental Disorder or Substance-Related and Addictive Disorder while the Member is confined to an Inpatient Treatment Center or Residential Treatment Center.
4. **Injectable Psychotropic Medications** – Injectable psychotropic medications are covered if prescribed by a USBHPC Participating Practitioner for treatment of a Mental Disorder.
5. **Psychological and Neuropsychological Testing** – Medically Necessary psychological testing is covered when authorized by USBHPC and provided by a Participating Practitioner who has the appropriate training and experience to administer such tests. Neuropsychological Testing does not require prior authorization unless required by the benefit plan.

Exclusions and Limitations

Unless described as a Covered Service in this document, the services and benefits described below are excluded from coverage under this Behavioral Health Plan.

These exclusions and limitations do not apply to Medically Necessary services to treat severe mental illnesses (SMI) or serious emotional disturbances of a child (SED).

1. Any Inpatient confinement, treatment, service or supply not authorized by USBHPC, except in the event of an Emergency or Urgently Needed Service.
2. The following Outpatient treatments require preauthorization by USBHPC, except in the event of an Emergency: Intensive Outpatient Treatment, Outpatient Electro-Convulsive Treatment, Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment; Behavioral health Treatment for PDD/ Autism including Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention programs: Medical Detoxification; Methadone Maintenance

Treatment, and Psychological Testing. These services are excluded when not preauthorized and not provided in the event of an Emergency or Urgently Needed Service.

3. Services received prior to the Member's effective date of coverage, after the time coverage ends, or at any time the Member is ineligible for coverage.
4. Services or treatments which are not Medically Necessary, as determined by USBHPC.
5. Any services that the Member receives from a local, state or federal governmental agency are not covered, except when coverage under this behavioral health plan is expressly required by federal or state law.
6. Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) or Autism must have a treatment plan that has measurable goals over a specific timeline that is developed and approved by the Participating Qualified Autism Service Provider for the specific Member being treated; intensive behavioral intervention services are discontinued when the treatment goals and objectives are achieved or no longer appropriate. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to us upon request.
7. Treatments which do not meet national standards for mental health professional practice.
8. Routine custodial and convalescent care. This exclusion does not apply to authorized Medically Necessary covered services provided to a Member residing in a Custodial Care facility.
9. Any services provided by non-licensed Providers other than services provided to those Members diagnosed with PDD or autism that may be provided by a QAS provider, QAS professional or QAS paraprofessional as defined in the definitions section of this Evidence of Coverage.
10. Pastoral or spiritual counseling.
11. Dance, poetry, music or art therapy services except as part of a Behavioral Health Treatment Program.
12. School counseling and support services, household management training, peer-support services, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, Emergency aid to household items and expenses, and services to improve economic stability.
13. Genetic counseling services.
14. Community care facilities that provide 24-hour nonmedical residential care except when medically necessary.
15. Weight control programs and treatment for addictions to tobacco, nicotine or food.
16. Counseling for adoption, custody, family planning or pregnancy in the absence of a *DSM* diagnosis.
17. Personal or comfort items, and non-Medically Necessary private room and/or private-duty nursing during inpatient hospitalization are not covered.
18. With the exception of injectable psychotropic medication as set forth in **Section 4**, all nonprescription and prescription drugs, which are prescribed during the course of outpatient treatment, are not covered. Outpatient prescription drugs may be covered under your medical plan. Please refer to the Member disclosure materials describing the medical benefit. (Nonprescription and prescription drugs prescribed by a USBHPC Participating Practitioner while the Member is confined at an Inpatient Treatment Center and nonprescription and prescription drugs prescribed during the course of inpatient Emergency treatment whether provided by a Participating or Non-Participating Practitioner are covered under the inpatient benefit.)
19. Surgery.
20. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not Medically Necessary.
21. Treatment sessions by telephone or computer Internet services (instant messaging, chat rooms, etc.). Exception: Telehealth services that are audio/video (visual) based services delivered via a secure internet connection. Telehealth services must contain both real time audio and video components.

22. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations or career counseling.

23. Educational Services for Developmental Delays and Learning Disabilities. Educational Services for Developmental Delays and Learning Disabilities are not health care services and are not covered. Educational skills for educational advancement to help students achieve passing marks and advance from grade to grade are not covered. The Plan does not cover tutoring, special education/instruction required to assist a child to make academic progress: academic coaching, teaching members how to read; educational testing or academic education during residential treatment. Teaching academic knowledge or skills for the purpose of increasing your current levels of knowledge or learning ability to levels that would be expected from a person of your age are not covered.

    USBHPC refers to the *American Academy of Pediatrics, Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review* for a description of Educational Services.

    For example, USBHPC does not cover:

    - Items and services that increase academic knowledge or skills;
    - Special education (teaching to meet the educational needs of a person with intellectual disability, Learning Disability, or Developmental Delay.) (A Learning Disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age. A Developmental Delay is a delayed attainment of age appropriate milestones in the areas of speech-language, motor, cognitive, and social development.) This exclusion does not apply to covered services when they are authorized, part of a Medically Necessary treatment plan, provided by or rendered under the direct supervision of a licensed or certified healthcare professional, and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law.
    - Teaching and support services to increase academic performance;
    - Academic coaching or tutoring for skills such as grammar, math, and time management;
    - Speech training that is not Medically Necessary, and not part of an approved treatment plan and not provided by or under the direct supervision of a Participating Provider acting within the scope of his or her license under California law that is intended to address speech impediments;
    - Teaching how to read, whether or not member has dyslexia;
    - Educational testing;
    - Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, or swimming, or teaching you how to play. Play therapy services are covered only when they are authorized, part of a Medically Necessary treatment plan, require the supervision of a licensed physical therapist or a Qualified Autism Service Provider, and are provided by an authorized provider within the scope of his or her license or as authorized under California law. This exclusion does not apply to authorized Medically Necessary services to treat autism spectrum disorders or pervasive developmental disorders (PDD) or any other Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED).

24. Treatment of problems that are not Mental Disorders are not covered, except for diagnostic evaluation. This exclusion does not apply to treatment of Substance-Related and Addictive Disorders.

25. Experimental and/or Investigational Therapies, Items and Treatments are not covered, unless required by an external independent review panel as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Experimental and Investigational Therapies." Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by the USBHPC Medical Director or a designee. For the purpose of this *Combined Evidence of Coverage and Disclosure Form,* procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/ guidelines are met:

    - It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA), and such approval has not been granted at the time of its use or proposed use.

- It is a subject of a current investigation of new drug or new device (IND) applications on file with the FDA.
- It is the subject of an ongoing clinical trial (Phase I, II, or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and the Department of Health and Human Services.
- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
- It is being delivered or should be delivered subject to approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
- Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or Investigational itself pursuant to the above criteria but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab test or imaging ordered to evaluate the effectiveness of the Experimental therapy.)
- The source of information to be relied upon by USBHPC in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this Behavioral Health Plan, include, but are not limited to the following:
  - The Member's Medical records;
  - The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
  - Any informed consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
  - The published authoritative medical and scientific literature regarding the drug, device, treatment or procedure;
  - Expert medical opinion;
  - Opinions of other agencies or review organizations (e.g., ECRI Health Technology Assessment Information Services or HAYES New Technology Summaries);
  - Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Healthcare Research and Quality (AHRQ);
  - USBHPC Technology Assessment Committee Guidelines.

A Member with a Life-Threatening or Seriously Debilitating condition may be entitled to an expedited external independent review of USBHPC's coverage determination regarding Experimental or Investigational therapies as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Experimental and Investigational Therapies."

26. Services provided to the Member on a non-participating basis other than if authorized by the Plan. **Exception:** If you received Covered Services at a Participating Facility at which or as a result of which you received services provided by a Non-Participating Provider, you will pay no more than the same Co-payment or co-insurance you would pay for the same Covered Services received from a Participating provider.
27. Services rendered by a Non-Participating Provider are not covered, except for Emergency Services, Urgently Needed Services, or services authorized by USBHPC.
28. Services rendered outside the Service Area are not covered, except for Emergency Services or Urgently Needed Services.
29. Services following discharge after receipt of Emergency Services or Urgently Needed Services are not covered without a Participating Provider's or USBHPC's authorization. The fact that the Member is outside the Service Area and that it is

inconvenient for the Member to obtain the required services from a Participating Provider will not entitle the Member to coverage.

SECTION 5. PAYMENT RESPONSIBILITY

- **What Are Premiums and Co-payments**
- **What To Do if You Get a Bill**
- **Coordinating Benefits Medicare Eligibility**
- **Workers' Compensation Eligibility**
- **Other Benefit Coordination Issues**

This section explains these and other Behavioral Health Care expenses. It also explains your responsibility when you are eligible for Medicare or Workers' Compensation coverage and when U.S. Behavioral Health Plan, California (USBHPC) needs to coordinate your Benefits with another Plan.

What are Premiums?

Premiums are fees an Employer Group pays to cover the basic costs of your Behavioral Health Services. An Employer Group usually pays these Premiums on a monthly basis. Often the Subscriber shares the cost of these Premiums with deductions from his or her salary.

If you are the Subscriber, you should already know your contribution to your Premium payment. If you are not sure, contact your employer's health benefits representative. He or she will know if you are contributing to your Premium, as well as the amount, method, and frequency of this contribution.

What are Co-payments?

You may be responsible for paying a charge when you receive Behavioral Health Services. This charge is called a Co-payment and is outlined in your *Schedule of Benefits*. As you review your *Schedule of Benefits*, you will see that the amount of the Co-payment depends on the service, as well as the provider from whom you choose to receive your care.

What is an Annual Deductible?

The Annual Deductible is the amount incurred for a Covered Services that you are responsible for paying each year before benefits are payable under the *Combined Evidence of Coverage and Disclosure Form* the Deductible is waived for certain Covered Services. Please refer to the Schedule of Benefits for detailed information on the Deductible amount and Covered services subject to the Deductibles. If your coverage includes a Deductible, we will not cover certain services until you meet the Deductible each year. The Annual Deductible applies to the Annual Out-of-Pocket Maximum.

Family Deductible. When the amount incurred for Covered Services for all Family Members accrue to the amount indicated on the *Schedule of Benefits*, no additional Annual Deductible will apply to the other Family Members for the rest of that year.

All Plans have an embedded individual/family deductible. The individual deductible is embedded in the family deductible. When an individual Member of a family unit satisfies the individual deductible for the year, no further Deductible will be required for that individual Member for the remainder of the year.

The remaining family Members will continue to pay full Member charges for services that are subject to the deductible until the Member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.

The calculation of your Annual Deductible and Family Deductible, if applicable, includes USBHPC benefits under this Combined Evidence of Coverage and Disclosure Form together with your Group Medical plan offered by your Employer Group. Your Annual Deductible and Family Deductible, if applicable, are identified in the Schedule of Benefits for your Group Medical Plan. Your Group Medical Plan and Schedule of Benefits will provide detail on how your Annual Deductible and Family Deductible, if applicable is calculated and applied. You should review the Schedule of Benefits for your Group Medical Plan to determine whether the Annual Deductible is applied on a calendar year or plan year basis.

Annual Out-of-Pocket Maximum

There is a limit placed on the total amount you pay towards your annual deductible (if any) and for Co-payments and Coinsurance each year. This limit is called your Annual Out-of-Pocket Maximum, and when you reach it, for the remainder of the year, you will not pay any additional Deductible, Co-payment or Coinsurance for Covered Services.

When an individual Member meets the Annual Out-of-Pocket Maximum, no further Co-payments, Coinsurance or Annual Deductible are required for the year for that individual.

If you have a Family Annual Out-of-Pocket Maximum, the Family Out-of-Pocket Maximum applies to the Deductible, Co-payments and Coinsurance paid by your Family. When your Family meets the Family Annual Out-of-Pocket Maximum, no further Co-payments, Coinsurance or Deductible are required for the remainder of the year for your family. An individual's Annual Out-of-Pocket Maximum is embedded in the Family Out-of-Pocket Maximum. When an individual Member of a family unit satisfies their individual Annual Out-of-Pocket Maximum for the Calendar Year, no further Co-Payments, Coinsurance or Annual Deductible are required for the year for that individual.

The calculation of your Annual Out-of-Pocket Maximum and Family Annual Out-of-Pocket Maximum, if applicable, includes USBHPC benefits under this combined Evidence of Coverage and Disclosure Form together with your Group Medical plan offered by your Employer Group. Your Annual Out-of-Pocket maximum and Family Annual Out-of-Pocket Maximum, if applicable, are identified in the Schedule of Benefits for your Group Medical Plan. Your Group Medical Plan and Schedule of Benefits for your Group Medical Plan will provide detail on how your Annual Out-of-Pocket Maximum is calculated and applied. You should review the Schedule of Benefits for your Group Medical Plan to determine whether the Annual Out-of-Pocket Maximum is applied on a calendar year or plan year basis.

What If You Get a Bill?

If you are billed for a Covered Service that has been authorized by USBHPC or if you receive a bill for Emergency or Urgently Needed Services, you should do the following:

1. Call the Provider, and then let them know you have received a bill in error, and you will be forwarding the bill to USBHPC.
2. Give the Provider your USBHPC Plan information, including your name and USBHPC Member number.
3. Forward the bill to:

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

Include your name, your USBHPC Health Plan ID number and a brief note that indicates you believe the bill is for a Covered Behavioral Health Service. The note should also include the date of service, the nature of the service and the name of the Provider who authorized your care. No claim form is required. If you need additional help, call our Customer Service department.

Please Note: Your Provider will bill you for services that are not covered by USBHPC or have not been properly authorized.

What is a *Schedule of Benefits*?

Your *Schedule of Benefits* is printed separately from this document and lists the Covered Behavioral Health Services for your Behavioral Health Plan. It also includes your Co-payments and Coinsurance, and other important information. If you need help understanding your *Schedule of Benefits*, or need a new copy, please call our Customer Service department.

Bills from Non-Participating Providers

If you receive a bill for a Covered Service from a provider who is not a Participating Provider, and the service was authorized, USBHPC will pay for the service, less the applicable Co-payment or Coinsurance, and Deductible. (Authorization is not required for Emergency Services and Urgently Needed Services. See **Section 3. Emergency Services and Urgently Needed Services.)** You are only required to pay the Co-payment or Coinsurance, and Deductible amount shown in your *Schedule of Benefits*. You may also submit a bill to us if a Non-Participating Provider has refused payment directly from USBHPC.

If you receive Covered Services in a Participating facility but from a Non-Participating individual health professional, you are only required to pay the Co-payment specified in your Schedule of Benefits. You should not be billed more than the amounts shown on your Schedule of Benefits.

You should file a claim within 90 days, or as soon as reasonably possible, of receiving any services and related supplies. Forward the bill to:

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

Include your name, USBHPC Plan ID number and a brief note that indicates your belief that you have been billed for a Covered service. The note should also include the date of service, the nature of the service and the name of the Provider who authorized your care. No claim form is required.

USBHPC will make a determination within 30 working days from the date USBHPC receives a claim containing all information reasonably needed to decide the claim. USBHPC will not pay any claim that is filed more than 180 calendar days from the date the services or supplies were provided.

USHPBC also will not pay for excluded services or supplies unless authorized directly by USBHPC.

How Do You Avoid Unnecessary Bills?

Always obtain your care under our direction. By doing this, you only will be responsible for paying any related Deductible Co-payments or Coinsurance.

Except for Emergency Services or Urgently Needed Services, if you receive services not authorized by USBHPC, you may be responsible for payment. This is also true if you receive any services not covered by your Plan. (Services not covered by your Plan are included in **Section 4. Covered Behavioral Health Services**.)

Your Billing Protection

If for any reason USBHPC is unable to pay for a Covered service on your behalf (for instance, in the unlikely event of USBHPC's insolvency or a natural disaster), you are not responsible for paying any bills as long as you received proper authorization. You may, however, be responsible for any properly authorized Covered services from a Non-Participating Provider or Emergency Services or Urgently Needed Services from a Non-Participating Provider.

Coordination of Benefits

Coordination of Benefits (COB) is a process, regulated by law, which determines the financial responsibility for payment when a person has group coverage for behavioral health services under more than one plan. "Plan" is defined below. COB is designed to provide maximum coverage for behavioral health services at the lowest cost by avoiding excessive or duplicate payments.

The objective of COB is to ensure that all group plans that provide behavioral health services to an individual will pay no more than 100 percent of the allowable expense for services that are received. This payment will not exceed total expenses incurred or the reasonable cash value of those services and supplies when the group plan provides benefits in the forms of services rather than cash payments.

USBHPC's COB activities will not interfere with your Behavioral Health Services

If you or your Dependent(s) are covered by both USBHPC and another plan or contract providing benefits or services for behavioral health, the services and benefits of your USBHPC Behavioral Health Plan will be coordinated with the other plan. Coordination between these plans provides maximum coverage for allowable expenses, thereby minimizing your out-of-pocket expenses and preventing costly duplication of payments.

The order of benefit determination rules below determines which Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100 percent of the total allowable expense. Allowable Expense is defined below.

Definitions

The following definitions only apply to coverage provided under this explanation of Coordination of Benefits.

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment.

   1. **Plan** includes: group insurance, closed panel (HMO, POS, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as Skilled Nursing Care; or other governmental benefits, as permitted by law (Medicare is not included as a Plan as defined here; however, USBHPC does coordinate benefits with Medicare. Please refer to the section entitled, Important Rules for Medicare and Medicare-Eligible Members.

   2. **Plan** does not include: non-group coverage of any type, including, but not limited to, individual or family insurance; amounts of hospital indemnity insurance of $200 or less per day; school accident-type coverage; benefits for nonmedical components of group long-term care policies; Medicare supplement policies, a state plan under Medicaid; and coverage under other governmental plans, unless permitted by law.

   Each contract for coverage under (1) above is a separate Plan. However, if the same carrier provides coverage to Members of a group under more than one group contract each of which provide for different types of coverage (for example, one covering dental services and one covering medical services), the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, 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. **Primary Plan or Secondary Plan** – The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when compared to another Plan covering the person.

   When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

C. **Allowable Expense** means a health care service or expense, including Deductibles and Co-payments, that is covered at least in part by any of the Plans covering the person. When a plan provides benefits in the form of services (for example, an HMO), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are **not** Allowable Expenses:

   1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in a private hospital room is

Medically Necessary) is not an Allowable Expense.

2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees 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 and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the allowable expense for all plans.

5. The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are precertification of admissions and preferred Provider arrangements.

D. **Claim Determination Period** means a calendar year or that part of the calendar year during which a person is covered by this Plan.

E. **Closed Panel Plan** is a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that has contracted with or is employed by the Plan, and that limits or excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel Member.

F. **Custodial Parent** means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

If the Member is covered by another group Health Plan, responsibility for payment of benefits is determined by the following rules. These rules indicate the order of payment responsibility among USBHPC and other applicable group Health Plans be establishing which plan is primary, secondary and so on:

A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. A Plan that does not contain a coordination of benefits provision is always primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to 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. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.

1. **Subscriber (Non-Dependent) or Dependent.** The Plan that covers the person other than as a Dependent, for example as an Eligible Employee, Member, Subscriber or retiree, is primary, and the plan that covers the person as a Dependent is secondary.

2. **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:

a. **Birthday Rule.** The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

- The parents are married;
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, that Plan is primary if the parent has enrolled the child in the Plan and provided the Plan with a copy of the court order as required in the "Eligibility" section of this *Combined Evidence of Coverage and Disclosure Form*. This rule applies to Claim Determination Periods or plan years, commencing after the Plan is given notice of the court decree.

c. If the parents are not married and/or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The Plan of the Custodial Parent;
- The Plan of the legal spouse or Domestic Partner of the Custodial Parent;
- The Plan of the non-Custodial Parent; and then
- The Plan of the legal spouse of the non-Custodial Parent.

3. **Active or Inactive Eligible Employee.** The Plan that covers a person as an Eligible Employee who is neither laid off nor retired (or his or her Dependent) is primary in relation to a Plan that covers the person as a laid-off or retired Eligible Employee (or his or her Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual by one Plan as a retired worker and by another Plan as a Dependent of an actively working legal spouse or Domestic Partner will be determined under the rule labeled D (1).

4. **COBRA Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA (Cal-COBRA)) also is covered under another Plan, the Plan covering the person as an Eligible Employee, Member, Subscriber or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. **Longer or Shorter Length of Coverage.** If the preceding rules do not determine the order of payment, the Plan that covered the person as an Eligible Employee, Member, Subscriber or retiree for the longer period is primary.

Effect on the Benefits of This Plan

- When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than 100 percent of total Allowable Expenses.
- If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the person's having received services from 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 or behavioral health coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans.

USBHPC may obtain the facts it needs 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. Each person claiming benefits under this Plan must give USBHPC any facts it needs to apply those rules and determine benefits payable. USBHPC may use and disclose a Member's protected health information for the purposes of carrying out treatment, payment or health care operations, including, but not limited to, diagnoses payment of health care services provided, billing, claims management or other administrative functions of USBHPC, without obtaining the Member's consent, in agreement with state and federal law.

USBHPC's Right to Pay Others

A "payment made" under another Plan may include an amount that should have been paid under this Plan. If this happens, USBHPC may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. USBHPC 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 includes providing benefits in the form of services, in which case, payment made means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

Important Rules for Medicare and Medicare-Eligible Members

You must let USBHPC know if you are enrolled, or eligible to enroll, in Medicare (Part A and/or Part B coverage). USBHPC is typically primary (that is, USBHPC's benefits are determined before those of Medicare) to Medicare for some initial period of time, as determined by the Medicare regulations. After the initial period of time, USBHPC will be secondary to Medicare (that is, the benefits under this Plan will be reduced to the extent they duplicate any benefits provided or available under Medicare, if the Member is enrolled or eligible to enroll in Medicare.)

You can become entitled to Medicare three different ways: because of age, disability, or end stage renal disease (ESRD).

If you have group health insurance through a plan that either you or your legal spouse received through and Employer Group that you are actively working at, that insurance is primary over Medicare. However, there are three exceptions to this rule:

1. Employer Group with less than 20 Eligible Employees;
2. Disabled individual; or
3. Members who are entitled to Medicare due to End Stage Renal Disease (ESRD).

Medicare is primary for Employer Groups that have fewer than 20 full-and part-time Eligible Employees. Also, Medicare is primary for disabled Members if their Employer Group has fewer than 100 Eligible Employees.

If you have questions about the coordination of Medicare benefits, contact your Employer Group or our Customer Service department. For questions regarding Medicare eligibility, contact your local Social Security office.

Workers' Compensation

USBHPC will not provide or arrange for benefits, services or supplies required due to a work-related injury or illness. This applies to injury or illness resulting from occupational accidents or sickness covered under any of the following: the California Workers' Compensation Act, occupational disease laws, employer's liability or federal, state or municipal law, To recover benefits for a work-related illness or injury, the Member must pursue his or her rights under the Workers' Compensation Act or any other law that may apply to the illness or injury. This includes filing an appeal with the Workers' Compensation Appeals Board.

If for any reason USBHPC provides or arranges for benefits, services or supplies that are otherwise covered under the Workers' Compensation Act, the Member is required to reimburse USHBPC for the benefits, services or supplies provided or arranged for, at Prevailing Rates, after receiving a monetary award, whether by settlement or judgment. The Member must also hold any settlement or judgment collected due to a workers' compensation action in trust for USBHPC. This award will be the lesser of the amount the Member recovers or the reasonable value of all services and benefits provided to him or her or on his or her behalf by USBHPC for each incident. If the Member receives a settlement from workers' compensation coverage that includes payment of future behavioral health costs, the Member must reimburse USBHPC for any future behavioral health expenses related to this judgment if USHBPC covers those services.

When a legitimate dispute exists as to whether an injury or illness is work-related, USBHPC will provide or arrange for benefits until such dispute is resolved, if the Member signs an agreement to reimburse USBHPC for 100 percent of the benefits provided.

USBHPC will not provide or arrange for benefits or services for a work-related illness or injury when the Member fails to file a claim within the filing period allowed by law or fails to comply with other applicable provisions of law under the Workers' Compensation Act. Benefits will not be denied to a Member whose employer has not complied with the laws

and regulations governing workers' compensation insurance, provided that such Member has sought and received Medically Necessary Covered Services under this Plan.

Third-Party Liability – Expenses Incurred Due to Liable Third Parties Are Not Covered

Expenses incurred for Behavioral Health Services by a Member for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party are expressly excluded from coverage under this Behavioral Health Plan. However, in all cases, USBHPC will pay for the arrangement or provision of behavioral health services for a Member that would have been Covered services except that they were required due to a liable third party, in exchange for the agreement as expressly described in the section of the *Combined Evidence of Coverage and Disclosure Form* captioned, USBHPC's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Behavioral Health Services.

USBHPC's Right to the Repayment of a Debt as a Charge against Recoveries from Third Parties Liable for a Member's Behavioral Health Care Expenses

Expenses incurred by a Member for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party are expressly excluded from coverage under this Behavioral Health Plan. However, in all cases, USBHPC will pay for the arrangement or provision of behavioral health services for a Member that would have been Covered services except that they were required due to a liable third party, in exchange for the following agreement:

If a Member is injured by a liable third party, the Member agrees to give USBHPC, or its representative, agent, or delegate, a security interest in any money the Member actually recovers from the liable third party by way of any final judgment, compromise, settlement or agreement, even if such money becomes available at some future time.

If the Member does not pursue, or fails to recover (either because no judgment is entered or because no judgment can be collected from the liable third party), a formal, informal, direct or indirect claim against the liable third party, then the Member will have no obligation to repay the Member's debt to USBHPC, which debt shall include the cost of arranging or providing otherwise Covered services to the Member for the care and treatment that was necessary because of the liable third party.

The security interest the Member grants to USBHPC, its representative, agent, or delegate applies only to the actual proceeds, in any form, that stem from any final judgment, compromise, settlement or agreement relating to the arrangement or provision of the Member's behavioral health services for injuries caused by a liable third party.

Non-Duplication of Benefits with Automobile, Accident or Liability Coverage

If you are receiving benefits as a result of automobile, accident or liability coverage, USBHPC will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident or liability coverage when such payments can reasonably be expected and to notify USBHPC of such coverage when available. USBHPC will provide Covered Behavioral Health Services over and above your automobile, accident or liability coverage, if the cost of your behavioral health services exceeds such coverage.

SECTION 6. MEMBER ELIGIBILITY

- **Membership Requirements**
- **Adding Family Members**
- **Termination of Benefits**
- **Updating Your Enrollment Information**
- **COBRA Benefits**

- **Total Disability**

This section describes how you become a U.S. Behavioral Health Plan, California (USBHPC) Member, as well as how you can add Family Members to your coverage. It will also answer other questions about eligibility, such as when late enrollment is permitted. In addition, you will learn ways you may be able to extend your USBHPC coverage when it would otherwise terminate.

Who is a USBHPC Member?

There are two kinds of USBHPC Members: Subscribers and enrolled Family Members (also called Dependents). The Subscriber is the person who enrolls through his or her employer-sponsored health benefit plan. The Employer Group, in turn, has signed a Group Agreement with USBHPC.

The following Family Members are eligible to enroll in USBHPC:

1. The Subscriber's legal spouse or Domestic Partner;
2. The biological children of the Subscriber or the Subscriber's legal spouse or the Domestic Partner (stepchildren) who are under the Limiting Age established by the employer (for an explanation of "Limiting Age," see **Definitions**);
3. Children who are legally adopted or placed for adoption with the Subscriber, the Subscriber's legal spouse or the Domestic Partner who are under the Limiting Age established by the employer;
4. Children for whom the Subscriber, the Subscriber's legal spouse or Domestic Partner has assumed permanent legal guardianship. Legal evidence of the guardianship, such as a certified copy of a court order, must be provided to USBHPC upon request; and
5. Children for whom the Subscriber, the Subscriber's legal spouse or Domestic Partner is required to provide health insurance coverage according to a qualified medical child support order assignment order, or medical support order, in this section.
6. Any child for whom the Subscriber has assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by intentional assumption of parental status, or assumption of parental duties by the Subscriber, as certified by the Subscriber at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled. Your Dependent children cannot be denied enrollment and eligibility due to the following:
    - Was born to a single person or unmarried couple;
    - Is not claimed as a Dependent on a federal income tax return;
    - Does not reside with the Subscriber or within the USBHPC Service Area.

Who is Eligible for Coverage?

All Members must meet all eligibility requirements established by the Employer Group and USBHPC. USBHPC's Member eligibility requirements are:

- The Member must have a primary residence or primary workplace within the USBHPC Plan Service Area; and
- The Member must meet any other eligibility requirements established by the Employer Group, such as exhaustion of a waiting period before an Eligible Employee can enroll in USBHPC. Employers will also establish the Limiting Age, the age limit for providing coverage to children.

Eligible Family Members must enroll under this USBHPC Behavioral Health Plan at the same time as the Subscriber or risk not being eligible to enroll until the employer's next Open Enrollment Period, as explained below. Circumstances which allow for enrollment outside the Open Enrollment Period are also explained below. All applicants for coverage must complete and submit to USBHPC all applications or other forms or statements that USBHPC may reasonably request.

Enrollment is the completion of a USBHPC enrollment form (or a nonstandard enrollment form approved by USBHPC) by the Subscriber on his or her own behalf or on the behalf of any eligible Family Member. Enrollment is conditional

upon acceptance by USBHPC, the existence of a valid Employer Group Agreement, and the timely payment of applicable Plan Premiums. USBHPC may, in its discretion and subject to specific protocols, accept enrollment data through an electronic submission.

Effective Date of Coverage for New Subscribers and Family Members to be added outside the Open Enrollment Period

Coverage for a newly enrolled Subscriber and his or her eligible Family Members begins on the date agreed to by the Employer Group or under the terms of the signed Group Agreement provided USBHPC receives the completed enrollment form and any required Premium within 30 days of the date the Subscriber becomes eligible to enroll in the Plan.

The effective date of enrollment when adding Family Members outside of the initial, Special, or Open Enrollment Period is explained below.

Open Enrollment

Most Members enroll in USBHPC during the Open Enrollment Period established by the Employer Group. This is the period of time established by the employer when its Eligible Employees and their eligible Family Members may enroll in the employer's health benefit plan.

Adding Family Members to your Coverage

The Subscriber's legal spouse or Domestic Partner and eligible children may apply for coverage with USBHPC during the employer's Open Enrollment Period. If you are declining enrollment for yourself or your Dependents (including your legal spouse or Domestic Partner) because of other Behavioral Health Plan insurance or group Behavioral Health Plan coverage, you may be able to enroll yourself and your Dependents in USBHPC if you and your Dependents lose eligibility for that other coverage (or if the Employer Group stops contributing toward you and your Dependents other coverage). However, you must request enrollment within 60 days after your or your Dependent's other coverage ends (or after the Employer Group stops contributing toward your or your Dependent's other coverage). In addition, if you have a new Dependent due to assumption of a part-child relationship, marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, assumption of a parent-child relationship or placement for adoption. (Guardianship is not a qualifying event for other Family Members to enroll.) New Family Members may be added outside the Open Enrollment Period if they meet any of the following. To obtain more information, call our Customer Service department.

Family Members are invited to enroll in the USBHPC Behavioral Health Plan, as long as they meet your Employer Group's eligibility requirements. Please note that you may be asked to provide a marriage certificate, affidavit of domestic partnership, birth certificate or legal adoption paperwork. If you:

1. **Getting married.** When a new legal Spouse or child becomes an eligible Family Member as a result of marriage, coverage begins on the date of the marriage if we receive a completed application to enroll a legal spouse or child eligible due to marriage within 60 days of the marriage.

2. **Domestic Partnership.** When a new Domestic Partner or Domestic Partner's child becomes an eligible Family Member as a result of a domestic partnership, coverage begins on the date of the domestic partnership. An application to enroll a Domestic Partner or child eligible as a result of a domestic partnership must be made within 60 days of the domestic partnership.

3. **Having a baby.** Newborns are covered for the first 60 days of life. In order for coverage to continue beyond the first 60 days of life, a Change Request Form must be submitted to USBHPC prior to the expiration of the 60-day period. If you do not enroll the newborn child within 60 days, the newborn is covered for only 31 days (including the date of birth).

4. **Adoption or Placement for Adoption.** Subscriber may enroll an adopted child if Subscriber obtains an adoptive placement from a recognized county or private agency, or if the child was adopted as documented by a health Facility minor release form, a medical authorization or a relinquishment form, granting Subscriber, Subscriber's legal spouse or Domestic Partner the right to control the health care for the adoptive child or absent such a document, on the date there exists evidence of the Subscriber's legal spouse's or Domestic Partner's right to control the health care of the child placed

for adoption. For adopted children, coverage is effective on the date of adoption or placement for adoption. An application must be received within 60days of the adoption placement.

5. **Assumption of a Parent-Child Relationship or Guardianship.** To enroll a Dependent child for whom the Subscriber, a Subscriber's legal spouse or Domestic Partner has assumed legal guardianship or assumption of a parent-child relationship, the Subscriber must submit a Change Request Form to USBHPC and for legal guardianship, a certified copy of a court order granting guardianship within 60 days of when the Subscriber, Subscriber's legal spouse or Domestic Partner assumed legal guardianship. Coverage will be retroactively effective to the date the Subscriber assumed legal guardianship or a parent-child relationship.

Qualified Medical Child Support Order

A Member (or a person otherwise eligible to enroll in the USBHPC Behavioral Health Plan) may enroll a child who is eligible to enroll in the USBHPC Behavioral Health Plan upon presentation of a request by a District Attorney, State Department of Health Services or a court order to provide medical support for such a Dependent child without regard to any enrollment period limitations.

A person having legal custody of a child or a custodial parent who is not a USBHPC Member may ask about obtaining Dependent coverage as required by a court or administrative order, including a Qualified Medical Child Support Order, by calling USBHPC's Customer Service Department. A copy of the court or administrative order must be included with the enrollment application. Information including, but not limited to, *Combined Evidence of Coverage and Disclosure Form* or other available information, including notice of termination, will be provided to the custodial parent, caretaker and/or District Attorney. Coverage will begin on the date of the court or administrative order provided USBHPC receives the completed enrollment form with the court or administrative order attached and any required Plan Premium.

Except for Emergency and Urgently Needed Services, to receive coverage, all care must be provided or arranged in the USBHPC Service Area by a Participating Provider.

Continuing Coverage for Students and Certain Disabled Dependents

Certain Dependents who would otherwise lose coverage under the Behavioral Health Plan due to their attainment of the Limiting Age established by the Employer Group may extend their coverage under the following circumstances:

Continuing Coverage for Student Dependents. A Dependent who is registered as a full-time student at a certified educational institution and is carrying a course load of a minimum of twelve (12) credit hours, or an equivalent, each academic period may continue as an eligible Dependent through the Limiting Age established by the employer for full-time students, if proof of such status is provided to USBHPC on a periodic basis, as requested by USBHPC. Breaks in the school calendar will not disqualify the Dependent student from coverage. If the Dependent student resides outside of the Service Area, the student must maintain a permanent address inside the Service Area with the Subscriber and the student must select a Participating Provider within 30 miles of that address. All Behavioral Health Services must be provided or arranged for in the Service Area by the designated Participating Provider, except for Emergency and Urgently Needed Services.

If the Dependent student takes a medical leave of absence from school, and the nature of the student's injury, illness, or condition would render the Dependent student incapable of self-sustaining employment, and the Dependent student is chiefly dependent on the Enrollee for support and maintenance, the student's coverage shall not terminate.

If the Dependent student takes a medical leave of absence from school but the nature of the Dependent student's injury, illness or condition does not meet the requirements described in the preceding paragraph, the student's coverage shall not terminate for a period not to exceed 12 months or until the date on which the coverage is scheduled to terminate, whichever comes first. The period of coverage shall commence on the first day of the medical leave of absence from the school or on the date the physician determines the illness prevented the dependent child from attending school, whichever comes first. Any break in the school calendar shall not disqualify the dependent child from coverage under this section

Continuing Coverage for Certain Disabled Dependents. Enrolled Dependents who attain the Limiting Age may continue enrollment in the Behavioral Health Plan beyond the Limiting Age established by the Employer Group if the Dependent meets all of the following:

- The Dependent is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and
- The Dependent is chiefly Dependent upon the Subscriber for support and maintenance.

At least 90 days prior to a disabled Dependent reaching the Limiting Age, USBHPC will send notice to you, the Subscriber, that coverage for the disabled Dependent will terminate at the end of the Limiting Age unless proof of such incapacity and dependency is provided to USBHPC by the Member within 60 days of receipt of notice. USBHPC shall determine if the disabled Dependent meets the conditions above prior to the disabled Dependent reaching the Limiting Age. Otherwise, coverage will continue until USBHPC makes a determination.

USBHPC may require ongoing proof of a Dependent's incapacity and dependency, but not more frequently than annually after the two-year period following the Dependent's attainment of the Limiting Age. This proof may include supporting documentation from a state or federal agency or a written statement by a licensed psychologist, psychiatrist or other Physician to the effect that such disabled Dependent is incapable of self-sustaining employment by reason of physical or mental disabling injury, illness or condition.

If you are enrolling a disabled child for new coverage, USBHPC may request initial proof of incapacity and dependency of the child and then yearly, to ensure that the child continues to meet the conditions above. You, as the Subscriber, must provide USBHPC with the requested information within 60 days of receipt of the request. The child must have been covered as a dependent of the Subscriber or legal spouse under a previous plan at the time the child reached the age limit.

Late Enrollment

In addition to a special enrollment period due to the addition of a new legal Spouse, Domestic Partner or child, there are certain circumstances when Eligible Employees and their eligible Family Members may enroll outside of the employer's open enrollment period. These circumstances include:

- The eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) declined in writing to enroll in USBHPC when they were first eligible because they had other health coverage; and

- USBHPC cannot produce a written statement from the Employer Group or eligible employee stating that prior to declining coverage, the eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) was provided with, and a signed acknowledgment of, an explicit written notice in boldface type specifying that failure to elect coverage with USBHPC during the initial enrollment period permits USBHPC to impose, beginning on the date the Eligible Employee (on his or her behalf, or on behalf of any eligible Dependents) elects coverage under the Behavioral Health Plan, an exclusion of coverage under the Behavioral Health Plan for a period of 12 months from the date of election of coverage under the Behavioral Health Plan, unless the eligible employee or Family Member can demonstrate that he or she meets the requirements for late enrollment.

- The other Behavioral Health Services are no longer available due to:

    - The employee or eligible Family Member exhausting COBRA or Cal-COBRA continuation coverage under another plan;

    - The termination of employment or reduction in work hours of a person through whom the Eligible Employee or eligible Family Member was covered; or

    - The termination of the other plan coverage; or

    - The cessation of an employer's contribution toward the employee or eligible Family Member coverage; or

- The death, divorce or legal separation of a person through whom the employee or eligible Family Member was covered.

- The loss of coverage under the Healthy Families Program due to exceeding the program's income or age limits, or loss of no-share-of-cost Medi-Cal coverage; or loss of coverage through the Covered California, California's Health Benefit Exchange; or

- The employee or eligible Family Member incurs a claim that would exceed a lifetime limit on all benefits; or

- The employee or eligible Family Member previously declined coverage under the Behavioral Health Plan, but the employee or eligible Family Member becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP) or the AIM Program. Coverage will begin only if we receive the completed enrollment application and any required Behavioral Health Plan Premium s within 60 days of the date of the determination of the subsidy eligibility; or

- The employee or eligible Family Member loses eligibility under Medicare or Children's Health Insurance Program (CHIP), the AIM Program, or the Medi-Cal program; or Covered California, California's Health Benefit Exchange. Coverage will begin only if we receive the completed enrollment application and any required Health Plan Premiums within 60 days of the date coverage ended.

- The Court has ordered behavioral health coverage to be provided for your Spouse or minor child.

  - Open Enrollment Period – You may enroll during the Open Enrollment period from November 1 of the preceding calendar year through January 31 of the benefit year, inclusive.
  - Special Open Enrollment Period – You may enroll within 60 days if one of the following events happens to one of your family Members:
    - The person loses Minimum Essential Coverage for a reason other than nonpayment of premium or rescission of coverage.
    - The person gains a Dependent or becomes a Dependent.
    - The person's enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous due to the plan's error, misrepresentation, or inaction.
    - The health coverage issuer violated a material provision of the health care coverage contract.
    - The person becomes eligible for membership due to a permanent move.
    - The person is mandated to be covered as a Dependent according to a valid state or federal court order.
    - The person has been released from incarceration.
    - The person was receiving services from a contracting Provider under another health benefit plan for one of the conditions described in the Continuity of Care Conditions as defined in Section 10. Definitions and that Provider is no longer a participating provider in the health benefit plan.
    - The person is a Member of the reserve forces of the United States military returning from active duty or a Member of the California National Guard returning from active duty services.

If the Eligible Employee or an eligible Family Member meets these conditions, the Eligible Employee must request enrollment with USBHPC following the termination of the other Behavioral Health Plan coverage as shown above. USBHPC may require proof of loss of the other coverage. Enrollment will be effective on the first of the following month if premium is received from the 1st to the 15th of the month. Enrollment will be effective on the first of the second succeeding month for premiums received on the 15th to the end of the month. Notwithstanding the above, coverage shall be effective on the date of birth, adoption, or placement of adoption for a new Dependent child due to birth, adoption or placement for adoption. Coverage shall be effective on the first day of the month following the date USBHPC receives the request for special enrollment in the case of anew legal spouse, Domestic Partner or loss of Minimum Essential Coverage.

Notifying You of Changes in Your Plan

Amendments, modifications or termination of the Group Agreement by either the Employer Group or USBHPC do not require the consent of a Member. USBHPC may amend or change the Health Plan, including the applicable Premiums, at any time after sending written notice to the Employer Group prior to the effective date of any amendment or change. Your Employer Group may also change your Health Plan benefits during the contract year. In accordance with USBHPC's Group Agreement, the Employer Group is obliged to notify Eligible Employees who are USBHPC Members of any such amendment or modification.

Updating Your Enrollment Information

Please notify your employer and USBHPC of any changes to the information you provided on the enrollment application within 31 days of the change. This includes changes to your name, address, telephone number, marital status or the status of any enrolled Family Members. For reporting changes in marital and/or Dependent status, please see Adding Family Members to Your Coverage.

Renewal Provisions

The *Group Subscriber Agreement* guarantees the benefits and rates for the period of that Agreement. Please contact your Employer Group to determine the term of the USBHPC *Group Subscriber Agreement*. The USBHPC *Group Subscriber Agreement* is automatically renewed for an additional period unless properly canceled by your Employer Group or USBHPC. At the time of renewal, USBHPC has the right to change Plan Premiums or other contract provisions. In addition, USBHPC reserves the right to amend the Agreement in accordance with any state or federal mandated law or regulation.

Ending Coverage

Usually, your enrollment in USBHPC terminates when the Subscriber or enrolled Family Member is no longer eligible for coverage under the employer's health plan. Your Employer Group determines the date in which coverage will terminate. Coverage can be terminated, however, because of other circumstances as well, which are described below.

Continuing coverage under this Plan is subject to the terms and conditions of the employer's Group Agreement with USBHPC.

When the Group Agreement between the Employer Group and USBHPC is terminated, all members covered under the Group Agreement become ineligible for coverage on the date of termination. If the Group Agreement is terminated by USBHPC for nonpayment of Premiums, coverage for all members covered under the Group Agreement will be terminated at the end of the 30-day grace period. The grace period shall begin no sooner than the first day following the last day of paid coverage. USBHPC will continue to provide coverage during the grace period.

According to the terms of the Group Agreement, the Employer Group is responsible for notifying you of termination by providing copy of the Notice of End of Coverage, or Notice of Cancellation, Rescission or Termination it receives from USBHPC.

Termination of Benefits

Termination of Group Agreement

USBHPC has the right to terminate the Group Agreement between Employer Group and USBHPC in the following situations:

- **For Nonpayment of Premiums.** The Group Agreement may be terminated if the Employer Group did not pay required Premiums when due. USBHPC will mail your Employer Group a Notice of Start of Grace Period no later than five (5) days after the last day of paid coverage. If the Employer Group fails to remit premium by the end of the Grace Period, USBHPC will mail a Notice of End of Coverage to the Employer Group no later than five (5) calendar days after the date coverage ended. Employer Group will provide copy of the Notice of Start of Grace Period and the Notice End of Coverage to Enrollees following its receipt from USBHPC as set forth in the Group Subscriber Agreement.

- **Termination for Reasons Other than Non-Payment of Premium**. If USBHPC terminates or cancels the Group Agreement for reasons other than Non-Payment of Premium, USBHPC shall send a Notice of Cancellation, Rescission, or Nonrenewal to Employer Group at least 30 days before the cancellation, rescission or nonrenewal, or time period otherwise noted in the descriptions below based on the reason for termination. A Notice of End of Coverage shall be sent following the date of termination. Reasons for termination other than non-payment of premium may include:

  - USBHPC confirms Employer Group demonstrates fraud or an intentional misrepresentation of material fact under the terms of the health care service plan contract.
  - USBHPC confirms Employer Group violates a material contract provision relating to employer contribution or group participation rates.
  - USBHPC ceases to provide or arrange for the provision of health benefits for new health care service plan contracts in the individual or group market, or all markets, in California, when the following conditions are satisfied:
    - USBHPC provides notice of its decision to cease new or existing health benefit plans in California to the Director of the Department of Managed Health Care, and the Employer Group, and the enrollees covered under those contracts at least 180 days prior to the discontinuation of those contracts
    - USBHPC shall not cancel the Plan for 180 days after the date of the notice described above and, shall continue to be governed by California rules and requirements during this period.
    - If USBHPC ceases to write new health benefit plans in the individual or group market, or all markets, in California, it shall be prohibited from offering for sale health benefit plans in that market or markets in California for a period of five (5) years from the date of the discontinuation.
  - USBHPC withdraws a health benefit plan in the individual or group market, when all of the following conditions are satisfied:
    - USBHPC notifies all affected Employer Groups and enrollees and the Director of the Department of Managed Health Care at least 90 days prior to the discontinuation of the Plan.
    - USBHPC makes available to the Employer Group all health benefit plans that it makes available to new group business.
    - In exercising the option to discontinue a health benefit plan under this paragraph and in offering the option of coverage under the above section, USBHPC acts uniformly without regard to the claims experience of the Employer Group or any health status-related factor relating to enrollees or potential enrollees.
  - USBHPC terminates coverage, in the case of a group health benefit plan, if the Employer Group ceases to be a member of a guaranteed association. Such termination will be made uniformly without regard to any health status-related factor relating to any enrollee.

Grievance Right. An enrollee, subscriber, or Employer Group (or their legal representative) has the right to submit a grievance if they believe the Group Agreement, or their enrollment or subscription has been or will be improperly terminated, cancelled, rescinded or not renewed. The grievance will be handled as an expedited grievance. A grievance may also be made electronically, verbally or in writing to the Director of the Department of Managed Health Care.

A “grievance” as used in this section means a written or oral expression of dissatisfaction to USBHPC or the Director of the Department of Managed Health Care regarding USBHPC and/or provider, including a written or oral expression of dissatisfaction by an enrollee, subscriber or Employer Group who believes their Group Agreement, enrollment, or subscription has been or will be improperly terminated, cancelled, rescinded or not renewed.

If you believe the Group Agreement or your coverage has been or will be wrongly canceled, rescinded or not renewed, please refer to, “**Grievances Involving the Termination, Rescission, Cancellation or Non-Renewal of Benefits your Health Plan”.** in **Section 7. Overseeing Your Behavioral Health Decisions** to learn how to request a review by the Department of Managed Care (DMHC) Director.

Termination/Rescission of Enrollee for Fraud or Misrepresentation

An Enrollee's coverage may be rescinded if USBHPC can demonstrate the enrollee performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the Group Agreement. "Rescission" is the cancellation of coverage for fraud or intentional misrepresentation of material fact that has a retroactive effect.

Under no circumstances will a Member be terminated due to health status or the need for Behavioral Health Services. Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for Behavioral Health Services may request a review of the termination by the DMHC. For more information contact the USBHPC Customer Service Department.

If USBHPC intends to terminate or rescind coverage as described above, USBHPC shall send notice to the enrollee via regular certified mail at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and notifying the enrollee of his or her right to appeal that decision to the director of the California Department of Managed Health Care.

USBHPC shall not terminate or rescind the plan contract for any reason after 24 months following issuance, and shall not cancel the contract, limit any of the provisions of the plan contract, or raise premiums on the plan contract due to any omissions, misrepresentations, or inaccuracies in the enrollment form, whether willful or not.

Other Reasons for Termination of Coverage Related to Loss of Eligibility

In addition to terminating the Group Agreement, USBHPC may terminate a Member's coverage for any of the following reasons related to loss of eligibility:

- The Member no longer meets the eligibility requirements established by the Group Employer.
- The Member no longer meets the eligibility requirements under the Health Plan because the Member establishes his or her Primary Residence outside the USBHPC Service Area and does not work inside the USBHPC Service Area (except for a Dependent Child, or a child subject to a qualified child medical support order, for more information refer to Qualified Medical Child Support Order in this section).

Under no circumstances will a Member be terminated due to health status or the need for health care services. If a Member is Totally Disabled when the group's coverage ends, coverage for the Totally Disabling condition may be extended (please refer below to Total Disability). Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care. For more information, call our Customer Service department.

Note: If a Group Subscriber Agreement is terminated by USBHPC, reinstatement with USBHPC is subject to all terms and conditions of the Group Subscriber Agreement between USBHPC and the Employer Group.

Ending Coverage – Special Circumstances for Enrolled Family Members

Enrolled Family Members terminate on the same date of termination as the Subscriber. If there is a divorce, the Spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered. Dependent children lose their eligibility if they reach the Limiting Age established by the employer and do not qualify for extended coverage as a disabled Dependent or student Dependent (see paragraph above entitled, Continuing Coverage for Students and Certain Disabled Dependents).

Total Disability

If you or your enrolled Dependent(s) is Totally Disabled as a result of a behavioral health condition at the time your Employer Group's Agreement with USBHPC is terminated and you or your enrolled Dependent(s) continue to be Totally Disabled, USBHPC will continue to provide coverage to the Totally Disabled Member for the behavioral health condition causing the Total Disability for up to twelve (12) months or until the Member is covered under another Health Plan which does not have an enforceable preexisting condition clause.

To qualify for these benefits, you must provide written proof of the behavioral health disability acceptable to USBHPC within ninety (90) days of the date on which coverage for your entire Employer Group was terminated. Also see the definition of "Totally Disabled or Total Disability" in the definitions section of this *Combined Evidence of Coverage and Disclosure Form.* USBHPC may require you to periodically submit additional information to verify your behavioral health Total Disability.

Coverage Options Following Termination

If your coverage through this Combined Evidence of Coverage and Disclosure Form ends, you and your enrolled Family Members may be eligible for additional continuation coverage.

Federal COBRA Continuation Coverage

If the Subscriber's Employer Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you may be entitled to temporarily extend your coverage under the Plan at group rates, plus an administration fee, in certain instances where your coverage under the Plan would otherwise end. This discussion is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. However, your Employer Group is legally responsible for informing you of your specific rights under COBRA. Therefore, please consult with your Employer Group regarding the availability and duration of COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if coverage under the group Plan is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage. Please consult with your Employer Group regarding any applicable premiums.

If you are a Subscriber covered by this Plan, you have a right to choose COBRA continuation coverage if you lose your group health coverage because either of the following qualifying events happens:

- Your hours of employment are reduced to less than the number of hours required for eligibility, or
- Your employment ends for any reason other than gross misconduct on your part.

If you are the legal spouse of a Subscriber covered by this Plan, you have the right to choose COBRA continuation coverage for yourself if you lose group health coverage under this Plan because any of the following qualifying events happens:

1. Your legal spouse dies;
2. Your legal spouse's hours of employment are reduced to less than the number of hours required for eligibility;
3. Your legal spouse's employment ends (for reasons other than his or her gross misconduct);
4. Your legal spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your legal spouse.

In the case of a Dependent child of a Subscriber enrolled in this Plan, he or she has the right to continuation coverage if group health coverage under this Plan is lost because any of the following qualifying events happens:

1. The Subscriber dies;
2. The Subscriber's hours of employment are reduced to less than the number of hours required for eligibility;
3. Subscriber's employment ends (for reasons other than his or her gross misconduct);
4. The Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The Subscribers become divorced or legally separated; or
6. The Dependent child ceases to be a Dependent eligible for coverage under this Plan.

When is COBRA Coverage available?

Your Employer Group (or, if applicable, its COBRA administrator) will offer COBRA continuation coverage to qualified beneficiaries only after they have been notified that a qualifying event has happened. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, or the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer Group must notify its COBRA administrator of the qualifying event. (Similar rights may apply to certain retirees, legal spouses and Dependent children if your Employer Group commences a bankruptcy proceeding and these individuals lose coverage.)

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Subscriber or a Dependent child losing eligibility for coverage as a Dependent child under the Plan), the Subscriber or enrolled Family Member has the responsibility to inform the Employer Group (or, if applicable, its COBRA administrator) within 60 days after the qualifying event happens. Please consult your Employer Group regarding its plan procedures for providing notice of qualifying events.

How is COBRA Coverage provided?

Once your Employer Group (or, if applicable, its COBRA administrator) receives notice that a qualifying event has happened, COBRA continuation coverage will be offered by the Employer Group (or its COBRA administrator) to each of the qualified beneficiaries. Under federal law, you must be given at least 60 days to elect COBRA continuation coverage. The 60-day election period is measured from the later of:

1. The date coverage ends due to a qualifying event; or
2. The date you receive the election notice provided by your Employer Group (or its COBRA administrator).

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Subscribers covered by this Plan may elect COBRA continuation coverage on behalf of their legal spouses and parents or legal guardians may elect COBRA continuation coverage on behalf of Dependent children. **If you do not choose COBRA continuation coverage on a timely basis, your group health insurance coverage under this Plan will end.**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Subscriber, the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), the

Subscriber's divorce or legal separation, or a Dependent child losing eligibility as a Dependent child under this Plan, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a Subscriber becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his legal spouse and Dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event. Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or any of your Family Members covered under this Health Plan is determined by the Social Security Administration to be disabled and you notify your Employer Group (or, if applicable, its COBRA administrator) in a timely fashion, you and your entire Family Members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total limit of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Please consult your Employer Group regarding their plan procedures for providing notice of disability.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If a Family Member experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the legal spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a limit of 36 months, if notice of the second qualifying event is properly given to your Employer Group (or, if applicable, COBRA administrator). This extension may be available to the legal spouse and any Dependent children receiving continuation coverage if the Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under this Health Plan as a Dependent child, but only if the event would have caused the legal spouse or Dependent child to lose coverage under this Health Plan had the first qualifying event not happened.

Please contact your Employer Group (or, if applicable, its COBRA administrator) for more information regarding the applicable length of COBRA continuation coverage available.

COBRA May Terminate Before Limit Coverage Period Ends.

Under COBRA, the continuation coverage may terminate before the limit coverage period if *any* of the following events happen:

1. Your Employer Group no longer provides group health coverage to any of its Eligible Employees;
2. The premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered after the date he or she elects COBRA continuation coverage under another group Health Plan;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA continuation coverage; or
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

COBRA Premium

Under the law, you may have to pay all of the premium for your continuation coverage. Premiums for COBRA continuation coverage is generally 102 percent of the applicable Health Plan Premium. However, if you are on a disability extension, your cost will be 150 percent of the applicable Premium. You are responsible for the

Timely submission of the COBRA premium to the Employer Group or COBRA administrator. Your Employer Group or COBRA administrator is responsible for the timely submission of Premium to USBHPC.

What to Do If You Have Questions About COBRA?

If you have any questions about your COBRA continuation coverage rights, please contact your Employer Group.

1401 Extended Continuation Coverage After COBRA

In the event your COBRA coverage began on or after January 1, 2003, and you have used all of your COBRA benefits as described above, you may be eligible to continue benefits under California Continuation Coverage at 110 percent of the Premium charged for similarly situated Eligible Employees currently working at your former employment. A notice will be provided to you by USBHPC at the time your COBRA benefits will run out, allowing up to 18 more months under California Continuation COBRA. However, your California Continuation COBRA benefits will not exceed a combined total of 36 months from the date COBRA coverage began.

Example: As a result of termination from your former employer (for reasons other than gross misconduct), you applied for and received 18 continuous months of group Health Plan benefits under your federal COBRA benefits. California Continuation COBRA may extend your benefits another 18 consecutive months. Your combined total of benefits between COBRA and California Continuation COBRA is 36 months.

1401 Extended Continuation Coverage Enrollment and Premium Information After COBRA

You must notify USBHPC within 60 days from the date your COBRA coverage terminated or will terminate because of your qualifying event if you wish to elect this continuation coverage, or within 60 days from the date you received notice from USBHPC. If you fail to notify USBHPC within 60 days of the date of your qualifying event, you will lose your rights to elect and enroll on California Continuation Coverage after COBRA. The 60-day period will be counted from the event which happened last. Your request must be in writing and delivered to USBHPC by first-class mail, or other reliable means of delivery, including personal delivery, express mail or private courier company. Upon receipt of your written request, an enrollment package to elect coverage will be mailed to you by USBHPC. You must pay your initial Premiums to USBHPC within 45 days from the date USBHPC mails your enrollment package after you notified USBHPC of your intent to enroll. Your first Premium must equal the full amount billed by USBHPC. Your failure to submit the correct Premium amount billed to you within the 45-day period, which includes checks returned to USBHPC by your financial institution for non-sufficient funds (NSF), will disqualify you from this available coverage and you will not be allowed to enroll.

Termination of 1401 Extended Continuation Coverage After COBRA

Your coverage under California Continuation Coverage will terminate when:

1. You have received 36 months of continuation coverage after your qualifying event date; or
2. If you cease or fail to make timely Premiums; or
3. Your former employer or any successor employer ceases to provide any group benefit plan to his or her Eligible Employees; or
4. You no longer meet eligibility for USBHPC coverage, such as moving outside the USBHPC Service Area; or
5. The contract for health care services between your employer and USBHPC is terminated; or
6. You become entitled for Medicare. **Note:** If you were eligible for the 29-month extension due to disability and you are later determined by the Social Security Administration to no longer be disabled, your benefits will terminate the later of 36 months after your qualifying event or the first of the month following 31 days from date of the final Social Security Administration determination, but only if you send the Social Security Administration notice to USBHPC within 30 days of the determination.
7. If you were covered under a prior carrier and your former employer replaces your prior coverage with USBHPC coverage, you may continue the remaining balance of your unused coverage with USBHPC, but only if you enroll with and pay Premiums to USBHPC within 30 days of receiving notice of your termination from the prior group Health Plan.

If the contract between your former employer and USBHPC terminates prior to the date your continuation coverage would terminate under California Continuation COBRA, you may elect continuation coverage under your former employer's new benefit plan for the remainder of the time period you would have been covered under the prior group benefit plan.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Continuation coverage under this Plan may be available to you through your employer under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). The continuation coverage is equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Behavioral Health Plan. These benefits may be available to you if you are absent from employment by reason of service in the United States' uniformed services, up to the maximum 24-month period if you meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through COBRA or Cal-COBRA. Your employer will provide written notice to you for USERRA continuation coverage.

If you are called to active military duty and are stationed outside of the Service Area, you or your eligible Dependents must still maintain a permanent address inside the Service Area and must choose a Participating Provider within 30 miles of that address. To obtain coverage, all care must be provided or arranged in the Service Area, except for Emergency Services and Urgently Needed Services.

The Premium for USERRA Continuation of benefits is the same as the Premium for other USBHPC Members enrolled through your employer plus a two percent additional surcharge or administrative fee, not to exceed 102 percent of your employer's active group Premium. Your employer is responsible for billing and collecting Premiums from you or your Dependents and will forward your Premiums to USBHPC along with your employer's Premiums otherwise due under this Agreement. Additionally, your employer is responsible for maintaining accurate records regarding USERRA continuation Member Health Plan Premium, qualifying events, terminating events and any other information that may be necessary for USBHPC to administer this continuation benefit.

California Military Families Financial Relief Act

Members of the United States Military Reserve and National Guard who terminate coverage as a result of being ordered to active duty on or after January 1, 2007, may have their coverage reinstated without waiting periods or exclusion of coverage for Pre-Existing Conditions. Please call Member Services for information on how to apply for reinstatement of coverage following active duty as a reservist.

SECTION 7. OVERSEEING YOUR BEHAVIORAL HEALTH DECISIONS

- **How USBHPC Makes Important Benefit Decisions**
- **Second Opinions**
- **New Treatment and Technologies**
- **Experimental and Investigational Therapies**
- **Grievances Involving the Termination, Rescission, Cancellation, or Non-Renewal of Benefits**
- **Appealing a Behavioral Health Benefit Decision**
- **Independent Medical Review**

This section explains how USBHPC authorizes or makes changes to your Behavioral Health Services, how we evaluate new behavioral health technologies and how we reach decisions about your coverage.

You will also find out what to do if you are having a problem with your Behavioral Health Plan, including how to appeal a behavioral health benefit decision by USBHPC or one of our Participating Providers. You will learn the process that is available for filing a formal grievance, as well as how to request an expedited decision when your condition requires a quicker review.

How USBHPC Makes Important Benefit Decisions

Authorization, Modification and Denial of Behavioral Health Services

When a Member requests Mental Health Services or **Substance-Related and Addictive Disorder** Services, USBHPC uses established utilization management (UM) criteria to approve, deny, delay or modify authorization of benefits based on Medical Necessity. The criteria used for evaluating Mental Health Services are based on empirical research and industry standards. These are the *MCAP Behavioral Health Criteria*. For **Substance-Related and Addictive Disorder** Services USBHPC uses the *American Society of Addiction Medicine Placement Guidelines for Substance Related Disorder – Version II-Revised*. The UM criteria used to deny, delay or modify requested services in the Member's specific case will be provided free of charge to the Participating Provider and to the Member. The public is also able to receive specific criteria or guideline, based on a particular diagnosis, upon request.

If you or your Dependent(s) are receiving Behavioral Health Services from a school district or a regional center, USBHPC will coordinate with the school district or regional center to provide Case Management of your Behavioral Health Treatment Program. Upon USBHPC's request, you or your Dependent(s) may be required to provide a copy of the most recent Individual Education Plan (IEP) that you or your Dependent(s) received from the school district and or the most recent Individual Program Plan (IPP) or Individual Family Service Plan (IFSP) from the regional center to coordinate these services.

The USBHPC qualified Physician or other appropriate qualified licensed health care professional, and its Participating Providers make decisions to approve, deny, delay or modify requests for authorization of Behavioral Health Services, based on Medical Necessity, within the following time frames as required by California state law:

- Decisions based on Medical Necessity will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days from USBHPC's receipt of information reasonably necessary to make the decision.
- If the Member's condition poses an imminent and serious threat to his/her health, including, but not limited to, severe pain, potential loss of life, limb or other major bodily functions, or lack of timeliness would be detrimental to the Member's life or health or in regaining maximum functions, the decision would be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed seventy-two (72) hours after USBHPC's receipt of the information reasonably necessary and requested by USBHPC to make the determination.

If the decision cannot be made within these time frames because (i) USBHPC is not in receipt of all the information reasonably necessary and requested, or (ii) USBHPC requires consultation by an expert reviewer, or (iii) USBHPC has asked that an additional examination or test be performed upon the Member, provided the examination or test is reasonable and consistent with good medical practice, USBHPC will notify the Participating Provider and the Member, in writing, that a decision cannot be made within the required time frame. The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by USBHPC, then USBHPC shall approve or deny the request for authorization within the time frame specified above as applicable.

USBHPC notifies requesting Participating Providers of decisions to approve, deny or modify request for authorization of Behavioral Health Services of Members within twenty-four (24) hours of the decision. Members and the Participating Provider are notified of decisions, in writing, within two (2) business days of the decision.

In the case of urgent concurrent review, USBHPC will review and render a decision within no more than seventy-two (72) hours taking into consideration the nature of the Member's condition and provide a response to the Participating Provider within twenty-four (24) hours of the decision. Care shall not be discontinued until the Member's treating provider has been notified of USBHPC's decision, and a care plan has been agreed upon by the treating Participating Provider that is appropriate for the medical needs of the patient.

The written decision will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, and information about how to file an appeal of the decision with USBHPC; this applies to all requests for services that are denied, delayed or modified. The decision will include a description of the criteria or guidelines used in making the decision. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Member. In the case of a request for retrospective services, the total time for making the retrospective review decision and notifying the Participating Provider and Member in writing shall not exceed thirty (30) calendar days from receipt of the claim/request. Written notification of the retrospective review determination is sent to the treating Participating Provider, facility, and Member and/or authorized member representative within thirty (30) days of the retrospective review request.

If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an "Urgent Request" as defined above, USBHPC will modify or deny the request as soon as possible, taking into account the Member's behavioral health condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to USBHPC at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an Urgent Request as defined above, USBHPC will treat the request as a new request for a Covered Service under the Behavioral Health Plan and will follow the time frame for non-Urgent requests as discussed above.

If you would like a copy of USBHPC's description of processes utilized for the authorization or denial of Behavioral Health Services, or the criteria or guidelines related to a particular condition, you may contact the USBHPC Customer Service Department or visit the USBHPC Web site at www.liveandworkwell.com.

Second Opinions

A Member, or his or her treating USBHPC Participating Provider, may submit a request for a second opinion to USBHPC either in writing or verbally through the USBHPC Customer Service Department. Second opinions will be authorized for situations, including, but not limited to, when:

- the Member questions the reasonableness or necessity of recommended procedures;
- the Member questions a diagnosis or plan for care for a condition that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment, including but not limited to a chronic condition;
- the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating Provider is unable to diagnose the condition and the Member requests an additional diagnosis;
- the Treatment Plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; or
- the Member has attempted to follow the plan of care or consulted with the initial Provider concerning serious concerns about the diagnosis or plan of care.

The request for a second opinion will be approved or denied by USBHPC's Medical Director (or designee) in a timely fashion appropriate for the nature of your or Dependent's condition. For circumstances other than an imminent or serious threat to your health, a second opinion request will be approved or denied within five business days after the Participating Provider or USBHPC receives the request. When there is an imminent and serious threat to your behavioral health, a decision about your second opinion will be made within 72 hours after receipt of the request by your Participating Provider or USBHPC.

If you are requesting a second opinion about care given by your Participating Provider, the second opinion will be provided by an appropriately qualified behavioral health professional of your choice within the same Participating Provider Network. If you request a second opinion about care received from a specialist the second opinion will be provided by any behavioral health professional of your choice from within the same Participating Provider Network. The Participating Provider providing the second opinion will possess the clinical background, including training and expertise, related to the illness or condition associated with the request for a second opinion.

If there is no qualified Participating Provider within the network, then USBHPC will authorize a second opinion by an appropriately qualified behavioral health professional outside the Participating Provider network. In approving a second opinion either inside or outside of the Participating Provider network, USBHPC will take into account the ability of the Member to travel to the Provider.

A second opinion will be documented by a consultation report which will be made available to you. If the Provider giving the second opinion recommends a particular treatment, diagnostic test or service covered by USBHPC, and it is determined to be Medically Necessary by your Participating Provider, the treatment, diagnostic test or service will be provided or arranged by the Member's Participating Provider. However, the fact that a Provider furnishing a second opinion recommends a particular treatment, diagnostic test or service does not necessarily mean that the treatment, diagnostic test or service is Medically Necessary or a Covered Service under your USBHPC Behavioral Health Plan. You will be responsible for paying any Co-payment, as set forth in your *Schedule of Benefits*, to the USBHPC Provider who renders the second opinion. If you obtain a second opinion without preauthorization from your Participating Provider or USBHPC, you will be financially responsible for the cost of the opinion.

If you or your Dependent's request for a second opinion is denied, USBHPC will notify you in writing and provide the reason for the denial. You or your Dependent may appeal the denial by following the procedures outlined in the appeals section described below.

To receive a copy of the Second Opinion policy, you may call or write the USBHPC Customer Service Department at:

U.S. Behavioral Health Plan, California
425 Market Street, 14th Floor
San Francisco, California 94105
1-877-449-6710

How are new treatment and technologies evaluated?

USBHPC is committed to evaluating new treatments and technologies in behavioral health care. A committee composed of USBHPC's Medical Director and people with subject matter expertise meet at least once a year to assess new advances and programs.

Experimental and Investigational Therapies

USBHPC also provides an external independent review process to review its coverage decisions regarding experimental or investigational therapies for USBHPC Members who meet all of the following criteria:

1. You have a Life-Threatening or Seriously Debilitating condition, as defined below and it meets the criteria listed in items #2, #3, #4 and #5 below:
   - "Life-threatening" means either or both of the following: (i) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (ii) diseases or conditions with potentially fatal outcomes, where the endpoint of clinical intervention is survival.
   - "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.
2. Your USBHPC Participating Provider certifies that you have a Life-Threatening or Seriously Debilitating condition, as defined above, for which standard therapies have not been effective in improving your condition, or for which standard therapies would not be medically appropriate for you, or for which there is no more beneficial standard therapy covered by USBHPC than the therapy proposed pursuant to paragraph (3); and
3. Either (a) your USBHPC Participating Provider has recommended a treatment, drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, and he or she included a statement of the evidence relied upon by the Participating Provider in certifying his or her recommendation; or (b) you, or your non-Participating Physician who is a licensed, board-certified or board-eligible Physician or Provider qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from medical and scientific evidence (as defined in California Health and Safety Code Section 1370.4(d)), is likely to be more beneficial for you than any available standard therapy.

   Such certification must include a statement of the evidence relied upon by the Physician in certifying his or her recommendation. USBHPC is not responsible for the payment of services rendered by non-Participating Providers that are not otherwise covered under the Member's USBHPC benefits; and
4. A USBHPC Medical Director (or designee) has denied your request for a drug, device, procedure or other therapy recommended or requested pursuant to paragraph (3); and
5. The treatment, drug, device, procedure or other therapy recommended pursuant to paragraph 3, above, would be a Covered Service, except for USBHPC's determination that the treatment, drug, device, procedure or other therapy is experimental or investigational. Independent Medical Review for coverage decisions regarding Experimental or Investigational therapies will be processed in accordance with the protocols outlined under "Independent Medical Review Involving a Disputed Health Care Service" Section of this *Evidence of Coverage.*

Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" Section found later in this *Combined Evidence of Coverage and Disclosure Form* for more information.

What to do if you have a problem?

Our first priority is to meet your needs and that means providing responsive service. If you ever have a question or problem, your first step is to call the USBHPC Customer Service Department for resolution.

If you feel the situation has not been addressed to your satisfaction, you may submit a complaint within 180 days of your receipt of an initial determination over the telephone or following any incident or action that is the subject of your dissatisfaction, by calling the USBHPC toll-free number at 1-877-449-6710. You can also file a complaint in writing or online as follows:

OptumHealth Behavioral Solutions of CA
P.O. Box 30512

Salt Lake City, UT 84130-0512
Attn: Appeals Department

Or at the USBHPC Web site: www.liveandworkwell.com

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

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

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

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

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

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

- You are not satisfied with USBHPC's decision about your complaint, or;
- You have not received the decision within 30 days or within 3 days if the problem is urgent.
- The DMHC may allow you to submit a complaint directly to the DMHC, even if you have not filed a complaint with USBHPC, if the DMHC determines that your problem requires immediate review.

For Help

Contact the DMHC Help Center at the toll-free telephone number **(1-888-466-2219)** to receive help with this process, or submit an inquiry in writing to the **DMHC, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725** or through the website: **www.dmhc.ca.gov**. The hearing and speech impaired may use the California Relay Service's toll-free telephone number **1-800-735-2929 or 1-888-877-5378 (TTY).**

Grievances Involving the Termination, Rescission, Cancellation or Non-Renewal of Benefits

If you believe that Employer's Group Subscriber Agreement with USBHPC, or your enrollment or subscription has been, or will be improperly terminated, rescinded, canceled or not renewed, you have the right to file a complaint with USBHPC. In addition to submitting complaint to USBHPC, you also have the right to submit a request to the Director of the Department of Managed Health Care (DMHC) to review your termination, cancellation, rescission, or non-renewal. You may submit a complaint to the DMHC even if you have not filed complaint with USBHPC first.

- You can file a complaint with USBHPC within at least 180 days from the date of the Notice of Start of Grace Period, Notice of End of Coverage, or Notice of Cancellation, Rescission or Non-Renewal that you allege to be improper by contacting the USBHPC customer service department at 1-800-449-6710. You can also file a complaint in writing or online as follows:

  OptumHealth Behavioral Solutions of California
  P.O. Box 30512
  Salt Lake City, UT 84130-0512
  Attn: Appeals Department
  Or at the USBHPC Website:
  www.liveandworkwell.com

- USBHPC must give you and DMHC with a written statement on the disposition or pending status of the complaint within three (3) calendar days of receipt of the complaint by USBHPC.
- You can file complaint with DMHC immediately without waiting for USBHPC's decision on your complaint as described below.

For Help

Contact the DMHC Help Center at the toll-free telephone number **(1-888-466-2219)** to receive help with this process, or submit an inquiry in writing to the **DMHC, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725** or through the website: **www.dmhc.ca.gov**. The hearing and speech impaired may use the California Relay Service's toll-free telephone number **1-800-735-2929 or 1-888-877-5378 (TTY).**

Appealing a Behavioral Health Benefit Decision

The individual initiating the appeal may submit an appeal within 180 days from the date of the initial benefit decision or following any incident or action that is the subject of the individual's dissatisfaction. An Appeal may be submitted by contacting USBHPC customer service or online as identified in this section. The individual may submit written comments, documents, records and any other information relating to the appeal regardless of whether this information was submitted or considered in the initial determination. The Member may obtain, upon request and free of charge, copies of all documents, records, and other information relevant to the Member's appeal. An individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person will review the appeal.

OptumHealth Behavioral Solutions of California
P.O. Box 30512
Salt Lake City, UT 84130-0512
Attn: Appeals Department

USBHPC toll-free number: 1-877-449-6710.

USBHPC Web site: www.liveandworkwell.com

The USBHPC Medical Director (or designee) will review your appeal and make a determination within a reasonable period of time appropriate to the circumstances but not later than thirty (30) days after USBHPC's receipt of the appeal, except in the case of "expedited reviews" discussed below. For appeals involving the delay, denial or modifications of Behavioral Health Services, USBHPC's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying or modifying Behavioral Health Services based on a finding that the services are not Covered Services, the response will specify the provisions in the plan contract that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of this *Combined Evidence of Coverage and Disclosure Form* captioned USBHPC Quality Review Process.

Expedited Review Process

Appeals involving an imminent or serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb or other major bodily functions will be immediately referred to the USBHPC Medical Director for expedited review, regardless of whether such appeal is received orally or in writing. If an appeal has been sent to the USBHPC Medical Director for immediate expedited review, USBHPC will immediately inform the Member, in writing, of his or her right to notify the Department of Managed Health Care. USBHPC will provide Member with a written statement on the disposition or pending status of the appeal no later than three (3) days from receipt of the appeal.

Independent Medical Review of Grievances Involving a Disputed Behavioral Health Service

A Member may request an Independent Medical Review (IMR) of disputed Behavioral Health Services from the Department of Managed Health Care (DMHC) if the Member believes that Behavioral Health Services have been improperly denied, modified or delayed by USBHPC. A "disputed Behavioral Health Service" is any Behavioral Health Service eligible for coverage under the *Evidence of Coverage* that has been denied, modified or delayed by USBHPC, in whole or in part because the service requested by you or your Provider based on a finding that the requested service is experimental or investigational or is not Medically Necessary. The Member must meet the criteria described in the "Eligibility" section to see if his or her grievance qualifies for an IMR. The IMR process is in addition to the procedures and remedies that are available to the Member under the USBHPC Appeal Process described above. If your complaint or appeal pertains to a disputed Behavioral Health Service subject to IMR (as discussed below), you should file your complaint or appeal within 180 days of receiving a denial notice.

Completed applications for IMR should be submitted to the DMHC. The Member pays no fee to apply for IMR. The Member has the right to include any additional information or evidence not previously provided to USBHPC in support of the request for IMR. USBHPC will provide the Member with an IMR application form with any grievance disposition letter that denies, modifies or delays Behavioral Health Services. The Member may also reach the DMHC by calling 1-888-HMO-2219. The DMHC fax number is 1-916-255-5241.

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

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

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

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

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

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

Disputed Behavioral Health Services Regarding Medical Necessity

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

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

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

Accepted Applications for the Independent Medical Review

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

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

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

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

After submitting all of the required materials to the IRO, USBHPC will promptly issue the Member a notification that includes an annotated list of the documents submitted and offer the Member the opportunity to request copies of those documents from USBHPC.

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

The Independent Medical Review Decision

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

- In the case of a review of Experimental or Investigational determination, if the Member's Provider determines that the proposed treatment or therapy would be significantly less effective if not promptly initiated. In this instance, the analysis and recommendations will be rendered within seven days of the request for expedited review. The review period can be extended up to three days for a delay in providing required documents at the request of the expert.
- If the Behavioral Health Services has not been provided and the Member's Provider or the DMHC certifies in writing that an imminent and serious threat to the Member's health exist, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of the Member's health. In this instance, any analyses and recommendation of the experts must be expedited and rendered within three days of the receipt of the Member's application and supporting information.
- If approved by the DMHC, the deadlines for the expert reviewers' analyses and recommendations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.
- The IRO will provide the DMHC, USBHPC, the Member and the Member's Provider with each of the experts' analyses and recommendations, and a description of the qualifications of each expert. The IRO will keep the names of the expert reviewers confidential, except in cases where the reviewer is called to testify and in response to court orders. In the case of an Experimental or Investigational determination, the experts' analyses will state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial to the Member than any available standard therapy and the reasons for recommending why the therapy should or should not be provided by USBHPC, citing the Member's specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the expert's recommendation.

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

When an Independent Medical Review Decision is Made

The DMHC will immediately adopt the decision of the IRO upon receipt and will promptly issue a written decision to the parties that will be binding on USBHPC. USBHPC will promptly implement the decision when received from the DMHC. In the case of an IRO determination requiring reimbursement for services already rendered, USBHPC will reimburse either the Member or the Member's Provider, whichever applies, within five working days. In the case of services not yet rendered to the Member, USBHPC will authorize the services within five working days of receiving the written decision from the DMHC, or sooner if appropriate for the nature of the Member's medical condition and will inform the Member and the Member's Provider of the authorization.

USBHPC will promptly reimburse the Member for reasonable costs associated with Urgently Needed Services or Emergency Services outside of USBHPC Participating Provider network, if:

- The services are found by the IRO to have been Medically Necessary;

- The DMHC finds the Member's decision to secure services outside of USBHPC's Participating Provider network prior to completing the USBHPC grievance process or seeking IMR was reasonable under the circumstances; and
- The DMHC finds that the disputed health care services were a covered benefit under the USBHPC Group Subscriber Agreement.

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

For more information regarding the IMR process, or to request an application, the Member should contact the USBHPC Customer Service Department at 1-877-449-6710.

The USBHPC Quality Review Process

The quality review process is a Member-initiated internal review process that addresses Member concerns regarding the quality or appropriateness of services provided by USBHPC Participating Providers that has the potential for an adverse effect on the Member. Upon receipt of the Member's concern, the concern is referred to the Quality Improvement Department for investigation.

USBHPC takes great pride in the quality of our Participating Providers. That is why complaints specifically about the quality of the care you receive from your Participating Provider are handled in an expedited fashion. Quality of care complaints that affect a Member's current treatment will be immediately evaluated and if necessary, other appropriate USBHPC personnel and the USBHPC Participating Provider will be consulted.

The Quality Improvement Manager (or designee) will be responsible for responding to questions the Member may have about his or her complaint and about the Quality Review process. In appropriate instances, a meeting may be arranged between the Member and the Participating Provider.

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

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

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care services plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-877-449-6710** or **711 for TTY (at operator request, enter "1-877-449-6710")** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal right or remedies that may be available to you. If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatment that are experimental or investigational in nature and payment disputes for Emergency or Urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

SECTION 8. MEMBER RIGHTS AND RESPONSIBILITIES

- **Your rights as a partner in your Behavioral Health Services**
- **USBHPC Member Responsibilities**
- **Confidentiality of Information**
- **Tell us what you think**

Think of USBHPC as part of your behavioral health care team. We want to work with you to ensure you receive the treatment and support you need. This Section describes the rights and responsibilities you have as a Member of USBHPC.

Your rights as a partner in your Behavioral Health Services

USBHPC believes in your rights as a partner in your own behavioral health care. USBHPC wants to give you all the information you need - in everyday language, not just medical words. Your rights include:

- Members have the right to receive information regarding how USBHPC protects the welfare and safety of Members and Care Managers.
- Members have the right to receive timely, quality care.
- Members have the right to receive information about USBHPC services, contracted providers, clinical guidelines and Case Management processes.
- Members have the right to be treated with respect and recognition of their dignity and need for privacy.
- Members have a right to participate with Participating Provider(s) in decision-making regarding their treatment planning.
- Members have a right to a candid discussion of appropriate and Medically Necessary treatment alternatives, regardless of cost or benefit coverage.
- Members have the right to voice complaints about the organization or the care provided as well as the right to appeal treatment authorizations, claims payment, or benefit interpretation decisions made by USBHPC without discrimination.
- Members may make recommendations regarding USBHPC's Member Rights and Responsibilities policies.

USBHPC will protect your rights regardless of your race, color, national origin, ancestry, sex, gender identity, disability. age, sexual orientation, marital status, culture, or economic, educational or religious background. These rights can also be given to the person you have named to make decisions about your health care. For more information on Member rights, visit the USBHPC website (www.liveandworkwell.com).

USBHPC Member Responsibilities

As a Member, you have many important responsibilities. These responsibilities include the following:

- Members have the responsibility to review information regarding Covered Services, exclusions, limitations, or Co-payments and policies and procedures as stated in Member materials and this *Combined Evidence of Coverage and Disclosure Form*.
- Members have a responsibility to provide, to the extent possible, information that either USBHPC or its Participating Provider(s) need(s) in order to provide for their care.
- Members have a responsibility to follow the Treatment Plans and instructions for care that they have agreed upon with their provider(s).

- Members have a responsibility to participate, to the degree possible, in understanding their behavioral health conditions and developing mutually agreed upon treatment goals.

- Members have the responsibility to accept financial responsibility for any Co-payment or coinsurance associated with services received while under the care of a USBHPC Participating Provider or while a patient at a USBHPC Participating Facility.

Confidentiality of Information

USBHPC takes the subject of Member confidentiality very seriously and takes great measures to protect the confidentiality of all Member information in its possession, including the protection of treatment records and personal information. USBHPC provides information only to the professionals delivering your treatment or as otherwise required by law. Confidentiality is built into the operations of USBHPC through a system of control and security that protects both written and computer-based information.

A STATEMENT DESCRIBING USBHPC'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. If you would like a copy of USBHPC's confidentiality policies and procedures, you may call our Customer Service Department at 1-800-999-9585.

Tell us what you think

Your questions and suggestions are important to us.

- Call or write USBHPC's Customer Service Department with all questions and concerns about your care.

- Give us your recommendations on how to improve your health plan, our customer service or our rights and responsibilities policies.

- Call or write the USBHPC Customer Service Department if you have a complaint.

- Ask any questions about the medical advice or treatment that you are getting.

Additionally, you have the right to voice complaints or file appeals about the organization or care provided. If you are denied services you feel are part of your benefits, you can file an appeal. To find out how to do this, please refer to the appeals process in Section Seven of this *Combined Evidence of Coverage and Disclosure Form.*

SECTION 9. GENERAL INFORMATION

- **What if I get a Bill?**
- **Confidentiality of Information**
- **Language Interpretation and Translation Services**
- **Coverage in Extraordinary Situations**
- **Nondiscrimination Notice**
- **Important Language Information**
- **Compensation for Providers**
- **Suspected Health Care Fraud**
- **Public Policy Participation**

What follows are answers to some questions about your coverage. If you have any questions of your own that have not been answered, please call our Customer Service Department.

What if I get a bill?

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

Forward the bill to:

U.S. Behavioral Health Plan, California
Claims Department
P.O. Box 30760
Salt Lake City, UT 84130-0760

For more information see Section 5. Payment Responsibility section of this *Combined Evidence of Coverage and Disclosure Form*.

Confidentiality of Information

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

Confidentiality is built into the operations of USBHPC through a system of control and security that protects both written and computer-based information.

A statement describing USBHPC's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request. If you would like a copy of USBHPC's confidentiality policies and procedures, you may call our Customer Service Department at 1-877-449-6710.

Does USBHPC offer language interpretation and translation services?

You can get an interpreter at no cost including but not limited to the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services to help you talk to your doctor or health plan. USBHPC uses a telephone interpretation service for almost 140 languages and dialects. That is in addition to the selection of Customer Service representatives who are fluent in a language other than English. Please refer to the USBHPC Participating Provider Directory at www.liveandworkwell.com for specific language interpretation availability. Notice of language assistance rights shall be available in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services. Certain translated member materials are also available upon request by calling USBHPC's Customer Service Department. To get help in your language, please call USBHPC's Customer Service Department at 1-877-449-6710.

Does USBHPC offer hearing and speech-impaired telephone lines?

USBHPC uses a national TTY (text telephone) and Hearing-Impaired Relay service for the hearing and speech impaired. To use these services, dial 1-800-735-2922 (voice telephone) or dial 711 (text telephone) and at the operator's request, say or enter 1-877-449-6710.

How is my coverage provided under extraordinary circumstances?

In the unfortunate event of a major disaster, epidemic, war, riot, civil insurrection or complete or partial destruction of facilities, our Participating Providers will do their best to provide the services you need. Under these extreme conditions, go to the nearest doctor or hospital for Emergency Services. USBHPC will later provide appropriate reimbursement.

Nondiscrimination Notice

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

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

If you think you were discriminated against, you may file a grievance with the plan and, if not resolved, you can file a grievance with the Department of Managed Healthcare ("DMHC"). For filing a grievance, please refer to “What to do if you have a Problem” under Section 7. Overseeing your Behavioral Health Decisions.

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

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

Important Language Information

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

You can get an interpreter in any of the top 15 languages spoken by limited English-proficient individuals at no cost to help you talk with your provider or health plan. USBHPC uses a telephone translation service for almost 140 languages and dialects. In addition to Customer Service representatives who are fluent in Spanish, translated Member materials are available upon request. Interpretation services are available at no charge to the member in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services. To get help in your language, please call your health plan at: U.S. Behavioral Health Plan, California at 1-877-449-6710/ TTY: 711.

Language services and the availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, will be at no charge and provided in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities. For further assistance, please contact USBHPC at 1-877-449-6710.

If you need more help, call HMO Help Line at 1-888-466-2219.

How does USBHPC compensate its Participating Providers?

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

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

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

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

What do you do if you suspect health care fraud?

USBHPC takes health care fraud by its Participating Providers or by its employees very seriously and has taken great measures to prevent, detect and investigate health care fraud. USBHPC has put in place policies and procedures to address fraud and report fraud to the appropriate law enforcement and regulatory entities in the investigation and prosecution of health care fraud. If you suspect fraud by any USBHPC Participating Provider or any USBHPC employee, please call the USBHPC anti-fraud hotline at 1-800-455-4521.

How can I participate in USBHPC'S Public Policy Committee?

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

SECTION 10. DEFINITIONS

U.S. Behavioral Health Plan, California is dedicated to making its services easily accessible and understandable. To help you understand the precise meaning of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your Combined Evidence of Coverage and Disclosure Form, as well as the Schedule of Benefits. Please refer to the Schedules of Benefits to determine which of the definitions below apply to your benefit plan.

Adverse Benefit Determination. Means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including the following:

- a determination of a Member's eligibility to take part in the Plan (including rescission);
- a determination that services are not covered based on certain exclusions or limitations on otherwise Covered Services; and
- a determination that benefits are Experimental or Investigational or not Medically Necessary or appropriate.

Annual Out-of-Pocket Maximum. The annual limit of Co-payments, Coinsurance and Deductible a Member is required to pay for Covered Services. The calculation of your Annual Out-of-Pocket Maximum includes USBHPC benefits under this combined Evidence of Coverage and Disclosure Form together with your Group Medical plan offered by your Employer Group. Your Annual Out-of-Pocket Maximum and Family Out-of-Pocket Maximum, if applicable, are identified in the Schedule of Benefits for your Group medical plan.

Behavioral Health Services. Services for the Medically Necessary diagnosis and treatment of Mental Disorders including but not limited to treatment for the Severe Mental Illness of a Person of Any Age and/or the Serious Emotional Disturbance of a Child under the Age of 18, and/or services for the treatment of **Substance-Related and Addictive Disorders,** which are provided to Members pursuant to the terms and conditions of the USBHPC Behavioral Health Plan.

Behavioral Health Plan. The USBHPC Behavioral Health Plan that includes coverage for the Medically Necessary diagnosis and treatment of Mental Disorders and **Substance-Related and Addictive Disorder**, as described in the Behavioral Health Group Subscriber Agreement, this *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits*.

Behavioral Health Treatment ("BHT") -. Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

- The treatment is prescribed by a licensed physician and surgeon of the California Business and Professions Code or developed by a licensed Participating psychologist pursuant to the California Business and Professions Code as authorized under California law.
- The treatment is provided under a treatment plan prescribed by a Participating Qualified Autism Service Provider and is administered by one of the following
- A Participating Qualified Autism Service Provider.
- A Participating Qualified Autism Service Professional supervised by a Participating Qualified Autism Service Provider.
- A Participating Qualified Autism Service Paraprofessional supervised by a Participating Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professional recognized standards of practice.

The treatment plan has measurable goals over a specific timeline that is developed and approved by the Participating Qualified Autism Service Provider for the specific Member being treated. The treatment plan shall be reviewed no less than once every six months by the Participating Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the Participating Qualified Autism Service Provider does all of the following:

- Describes the Member's behavioral health impairments or developmental challenges that are to be treated.
- Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported.
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
- Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to us upon request.

Behavioral Health Treatment Plan. A written clinical presentation of the USBHPC Participating Provider's diagnostic impressions and therapeutic intervention plans. The Behavioral Health Treatment Plan is submitted routinely to a USBHPC for review as part of the concurrent review monitoring process.

Behavioral Health Treatment Program. A structured treatment program aimed at the treatment and alleviation of **Substance-Related and Addictive Disorder** and/or Mental Disorders.

Benefit Plan Design. The specific behavioral health Benefit Plan Design for a Behavioral Health Plan which describes the benefit coverage, pertinent terms and conditions for rendering Behavioral Health Services, and the exclusions or limitations applicable to the Covered services.

Calendar Year. The period of time commencing 12 a.m. on January 1 through 11:59 p.m. on December 31.

Case Management. A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's behavioral health needs based on Medical Necessity, behavioral health benefits and available resources in order to promote a quality outcome for the individual Member.

Continuity of Care Condition(s). The completion of Covered Services will be provided by a terminated Participating Provider to a Member who at all time of the Participating Provider's contract termination was receiving any of the following Covered Services from that Participating Provider:

1. An Acute Condition: An acute condition is a behavioral health condition that involves a sudden onset of symptoms due to an illness, or other behavioral health problems that requires prompt medical attention and that has a limited duration. Completion of Covered Services will be provided for the duration of the acute condition.

2. A Serious Chronic Condition: A serious chronic condition is a behavioral health condition due to illness or other behavioral health conditions that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a Provider, as determined by the USBHPC Medical Director (or designee) in consultation with the Member, the terminated Participating Provider and as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed twelve (12) months from the agreement's termination.

3. Maternal Mental Health Condition: A "maternal mental health condition" is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery. Covered Services will be provided for an individual who presents written documentation of being diagnosed with a "maternal mental health condition" from the individual's treating health care provider for a period not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

4. Other Procedure: Other procedure that has been authorized by USBHPC or the Member's assigned Participating Provider as part of a documented course of treatment and had been recommended and documented by the terminated Participating Provider to occur within 180 calendar days of the Agreement's termination date.

Co-payments. The fee that a Member is obligated to pay, if any, at the time he or she receives a Covered Service either in-person or via telehealth modality. Co-payments may be a specific dollar amount or a percentage of the cost of the Covered Services as specified in this *Combined Evidence of Coverage and Disclosure Form* and are shown on the *Schedule of Benefits*.

Covered Services. Medically Necessary Behavioral Health Services provided pursuant to the Group Subscriber Agreement, this *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits*.

Custodial Care. Care and services required that assist the Member in the activities of daily living. Examples include assistance in walking, getting in or out of bed, bathing, dressing, feeding or using the toilet, preparation of special diets and supervision of medication that usually can be self-administering. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care is not covered under this USBHPC Behavioral Health Plan. **Exception:** Custodial Care may be covered if the services are Medically Necessary to treat SMI or SED.

Customer Service Department. The department designated by USBHPC to whom oral or written Member issues may be addressed. The Customer Service Department may be contacted by telephone at 1-877-449-6710 or in writing at:

U.S. Behavioral Health Plan, California
425 Market Street, 14th Floor
San Francisco, California 94105

Day Treatment Center. A Participating Facility which provides a specific Behavioral Health Treatment Program on a full- or part-day basis pursuant to a written Behavioral Health Treatment Plan approved and monitored by a USBHPC Participating Practitioner and which is also licensed, certified or approved to provide such services by the appropriate state agency.

Deductible. The Deductible is the amount incurred for Covered Services a Member is required to pay each year before benefits are payable under the Combined Evidence of Coverage and Disclosure Form. The calculation of your Annual Deductible includes USBHPC benefits under this combined Evidence of Coverage and Disclosure Form together with your Group Medical plan offered by your Employer Group. Your Annual Deductible is identified in the Schedule of Benefits for your Group medical plan

Dependent. Any Member of a Subscriber's family who meets all the eligibility requirements set forth by the Employer Group under this USBHPC Behavioral Health Plan and for whom applicable Plan Premiums are received by USBHPC.

Developmental Delay. A delayed attainment of age appropriate milestones in the areas of speech-language, motor, cognitive, and social development.

Diagnostic and Statistical Manual (*or "DSM"*). The *Diagnostic and Statistical Manual of Mental Disorders*, which is published by the American Psychiatric Association and which contains the criteria for diagnosis of Substance-Related and Addictive Disorder and Mental Disorders.

Domestic Partner is a person who meets the eligibility requirements, as defined by your Employer Group, and the following:

i. Is eighteen (18) years of age or older. An exception is provided to Subscribers and/or Dependents less than 18 years of age who have, in accordance with California Law, obtained:

- Written consent from the underage person's parents or legal guardian and a court order granting permission to the underage person to establish a domestic partnership.
- A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent or legal guardian capable of consenting to the domestic partnership.

ii. Is mentally competent to consent to contract.

iii. Is unmarried or not a member of another domestic partnership.

iv. Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

Emergency or Emergency Services. A behavioral health condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate Behavioral Health Services could reasonably be expected by the Member to result in any of the following:

- Immediate harm to self or others;
- Placing one's health in serious jeopardy;
- Serious impairment of one's functioning; or
- Serious dysfunction of any bodily organ or part.

Emergency Treatment. Medically Necessary ambulance and ambulance transport services provided through the 911 Emergency response system and medical screening, examination and evaluation by a Practitioner, to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if an Emergency for a Behavioral Health condition exists, and if it does, the care and treatment by a Practitioner necessary to relieve or eliminate the Emergency within the capabilities of the facility.

Experimental and Investigational. Please refer to the "Experimental and Investigational Therapies" section of this *Combined Evidence of Coverage and Disclosure Form*.

Employer Group. An employer, labor union, trust, organization, association or other entity to which the USBHPC Group Subscriber Agreement has been issued.

Family Member. The Subscriber's legal spouse or Domestic Partner and any person related to the Subscriber, legal spouse or Domestic Partner by blood, marriage, adoption or guardianship. An enrolled Family Member is a Family Member who is enrolled with USBHPC, meets all the eligibility requirements of the Subscriber's Employer Group and USBHPC, and for whom Premiums have been received by USBHPC. An eligible Family Member is a Family Member who meets all the eligibility requirements of the Subscriber's Employer Group and USBHPC.

Group Subscriber Agreement. The Agreement for the provision of Behavioral Health Services between the Group and USBHPC.

Inpatient Treatment Center. An acute care Participating Facility which provides Behavioral Health Services in an acute, inpatient setting, pursuant to a written Behavioral Health Treatment Plan approved and monitored by a USBHPC Participating Practitioner and which also:

a. provides 24-hour nursing and medical supervision; and
b. is licensed, certified, or approved as such by the appropriate state agency.

Learning Disability. A condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age.

Limiting Age. The age established by the Employer Group when a Dependent is no longer eligible to be an enrolled Family Member under the Subscriber's coverage. In no event shall the Limiting Age be less than 26 years of age.

Medical Detoxification. The medical treatment of withdrawal from alcohol, drug or other substance addiction is covered.

Medically Necessary (or Medical Necessity) refers to an intervention, if, as recommended by the treating Practitioner and determined by the Medical Director of USBHPC to be all of the following:

a. A health intervention for the purpose of treating a Mental Disorder or **Substance-Related and Addictive Disorder**;

b. The most appropriate level of service or item, considering potential benefits and harms to the Member;

c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and

d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. "Cost-effective" does not necessarily mean lowest price.

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

In applying the above definition of Medical Necessity, the following terms shall have the following meaning:

i. *Treating Practitioner* means a Practitioner who has personally evaluated the patient.

ii. A *health intervention* is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnosis, detect, treat or palliate) a Mental Disorder or **Substance-Related and Addictive Disorder** or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the Mental Disorder and **Substance-Related and Addictive Disorder** condition and the patient indications for which it is being applied.

iii. *Effective* means that the intervention can reasonably be expected to produce the intended result and to have expected benefits that outweigh potential harmful effects.

iv. *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

v. *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the Mental Disorder or **Substance-Related and Addictive Disorder** condition or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

vi. A *new intervention* is one that is not yet in widespread use for the Mental Disorder or **Substance-Related and Addictive Disorder** and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on

the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.

vii. An intervention is considered *cost-effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. The application of this criterion is to be on an individual case and the characteristics of the individual patient shall be determinative.

Member. The Subscriber or any Dependent who is enrolled, covered and eligible for USBHPC Behavioral Health Care coverage.

Mental Disorder. A mental health condition identified as a "mental health disorder" in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) that results in clinically significant distress or impairment of mental, emotional or behavioral functioning. Mental Disorders also include the Severe Mental Illness of a Person of Any Age and the Serious Emotional Disturbance of a Child, as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Please refer to the definitions of Severe Mental Illness and Serious Emotional Disturbance of a Child, respectively, in this **Section 10. Definitions.**

Mental Health Services. Medically Necessary Behavioral Health Services for the treatment of Mental Disorders, including but not limited to Severe Mental Illness and A Serious Emotional Disturbance of a Child, and services for the treatment of Substance-Related and Addictive Disorders.

Non-Participating Providers. Licensed psychiatrists, psychologists, marriage and family therapists, licensed clinical social workers, and other behavioral health professionals; qualified autism service providers, professionals and paraprofessionals; hospitals and other licensed behavioral health facilities which provide Behavioral Health Services to eligible Members, but have not entered into a written agreement with USBHPC to provide such services to Members.

Outpatient Treatment Center. A licensed or certified Participating Facility which provides a Behavioral Health Treatment Program in an outpatient setting.

Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment. A structured ambulatory program that may be freestanding or hospital-based and that provides services for at least five (5) hours per day and at least four (4) days per week. Partial hospital programs are used as a step-up from routine or intensive outpatient services, or as a step-down from acute inpatient or residential care. Partial hospital programs can be used to treat mental health conditions or substance-related and addictive disorders or can specialize in the treatment of co-occurring mental health conditions and substance-related and addictive disorders.

Participating Facility. An Inpatient Treatment Center, Day Treatment Center, Outpatient Treatment Center or Residential Treatment Center which is duly licensed in the State of California to provide either acute inpatient treatment, partial hospitalization, day treatment or outpatient care for the diagnosis and/or treatment of Mental Disorders and/or **Substance-Related and Addictive Disorder**, and which has entered into a written agreement with USBHPC.

Participating Practitioner. A psychiatrist, psychologist, nurse practitioner or other allied behavioral health care professional who is qualified and duly licensed and acting within the scope of their license, certified or otherwise authorized to practice his or her profession under the laws of the State of California and who has entered into a written agreement with USBHPC to provide Behavioral Health Services to Members.

Participating Providers. Participating Practitioners, Participating Qualified Autism Service Providers, Participating Provider Group Practices and Participating Facilities, collectively, each of which has entered into a written agreement with USBHPC to provide Behavioral Health Services to Members.

Participating Group Practice. A Provider group, entity or independent practice association duly organized and licensed, certified or otherwise authorized under the laws of the State of California to provide Behavioral Health Services through agreements with individual behavioral health care Providers, each of whom is qualified and appropriately licensed, certified or otherwise authorized to practice his or her profession in the State of California.

Participating Qualified Autism Service Provider - either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides

treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.

- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Participating Qualified Autism Service Professional - an individual who meets all of the following criteria:

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

Participating Qualified Autism Service Paraprofessional - an unlicensed and uncertified individual who as authorized under California law meets all of the following criteria:

- Is supervised by a Participating Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professional recognized standards of practice.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider.
- Meets education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
- Has adequate education, training, and experience, as certified by a Participating Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers.
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Plan Year. A period of one (1) year beginning on the effective date of the Group Subscriber Agreement between USBHPC and Employer Group and each year thereafter.

Practitioner. A psychiatrist, psychologist or other allied behavioral health care professional who is qualified and duly licensed or certified to practice his or her profession under the laws of the State of California.

Premiums. The periodic, fixed-dollar amount payable to USBHPC by the Employer Group for or on behalf of the Subscriber and the Subscriber's eligible Dependents in consideration of Behavioral Health Services provided under this Plan.

Psychiatric Emergency Medical Condition. A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

a. An immediate danger to himself or herself or to others

b. Immediately unable to provide for, or utilize, food, shelter or clothing, due to the mental disorder.

Psychological and Neuropsychological Testing – Psychological and Neuropsychological Testing includes the administration, interpretation, and scoring of tests such as WAIS-R, Rorschach, MMPI and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis.

Residential Treatment Center. A residential facility that provides services in connection with the diagnosis and treatment of behavioral health conditions including but not limited to Mental Disorders and Substance-Related and Addictive Disorders.

Schedule of Benefits. The schedule of Behavioral Health Services which is provided to a Members under this Behavioral Health Plan. The *Schedule of Benefits* is attached and incorporated in full and made a part of this document.

Serious Emotional Disturbance of a Child (SED) Under Age 18. A Serious Emotional Disturbance of a Child under Age 18 means a condition identified as a Mental Disorder in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), other than a primary substance use disorder or developmental disorder that result in behavior inappropriate to the child's age according to expected developmental norms if the child also meets at least one of the following three criteria:

1. As a result of the Mental Disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either:
   a. the child is at risk of removal from home or has already been removed from the home; or
   b. the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
2. The child displays psychotic features or risk of suicide or risk of violence due to a Mental Disorder; or
3. The child has been assessed pursuant to Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code and determined to have an emotional disturbance, as defined in paragraph (4) of subdivision (c) of Section 300.8 of Title 34 of the Code of Federal Regulations.

Service Area. The geographic area in which USBHPC is licensed to arrange for Behavioral Health Services in the State of California by the California Department of Managed Health Care.

Severe Mental Illness (SMI) of a Person of any Age. Severe Mental Illness of a person of any age includes the diagnosis and treatment of the following Mental Disorders:

- Anorexia Nervosa
- Bipolar Disorder (manic-depressive illness)
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder or autism, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism.
- Schizoaffective Disorder
- Schizophrenia

Subscriber. The person whose employment or other status except for being a Family Member, is the basis for eligibility to enroll in the USBHPC Behavioral Health Plan and who meets all the applicable eligibility requirements of the Group and USBHPC and for whom Plan Premiums have been received by USBHPC.

Substance-Related and Addictive Disorder. An addictive relationship between a Member and any drug, alcohol or chemical substance. **Substance-Related and Addictive Disorder** does not include addiction to or dependency on (1) tobacco in any form or (2) caffeine in any form.

Substance-Related and Addictive Disorder Inpatient Treatment Program. A structured medical and behavioral inpatient program aimed at the treatment and alleviation of **Substance-Related and Addictive Disorder.**

Substance-Related and Addictive Disorder Services. Medically Necessary services provided for the diagnosis and treatment of **Substance-Related and Addictive Disorder.**

Telehealth. The mode of delivering Covered Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the licensed health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

In applying the above definition, "asynchronous store and forward," "distant site," "originating site," and "synchronous interaction" shall have the following meanings:

- "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the licensed health care provider at a distant site without the presence of the patient.
- "Distant site" means a site where a licensed health care provider who provides Covered Services is located while providing these services via a telecommunications system.
- "Originating site" means a site where a patient is located at the time Covered Services are provided via a telecommunications system or where the asynchronous store and forward service originates.
- "Synchronous interaction" means a real-time interaction between a patient and a licensed health care provider located at a distant site.

Totally Disabled or Total Disability. The persistent inability to engage reliably in any substantially gainful activity by reason of any determinable physical or mental impairment resulting from an injury or illness. Totally Disabled is the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of a medically determinable physical or mental impairment resulting from an injury or illness. The disability must be related to a Behavioral Health condition, as defined in the *DSM*, in order to qualify for coverage under this USBHPC Plan. Determination of Total Disability shall be made by a USBHPC Participating Provider based upon a comprehensive psychiatric examination of the Member or upon the concurrence by a USBHPC Medical Director, if on the basis of a comprehensive psychiatric examination by a non-USBHPC Participating Provider.

Transitional Residential Recovery Services. Substance-Related and Addictive Disorder or chemical dependency treatment in a nonmedical transitional residential recovery setting. These settings provide counseling and support services in a structured environment.

Treatment Plan. A structured course of treatment authorized by a USBHPC Clinician, when appropriate, and for which a Member has been admitted to a Participating Facility, received Behavioral Health Services, and been discharged.

Urgent or Urgently Needed Services. Medically Necessary Behavioral Health Services received in an urgent care facility or in a Provider's office for an unforeseen condition to prevent serious deterioration of a Member's health resulting from an unforeseen illness or complication of an existing condition, such that treatment cannot be delayed.

USBHPC Clinician. A person licensed as a psychiatrist, psychologist, clinical social worker, marriage and family therapist, nurse or other health care professional licensed, certified or otherwise authorized under California law with appropriate training and experience in Behavioral Health Services, who is employed or under contract with USBHPC related to managing Covered Behavioral Health Services.

Visit. An outpatient session with a USBHPC Participating Practitioner conducted on an individual or group basis during which Behavioral Health Services are delivered.

NOTE: THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM CONSTITUTES ONLY A SUMMARY OF THE U.S. BEHAVIORAL HEALTH PLAN, CALIFORNIA (USBHPC) PLAN. THE GROUP SUBSCRIBER AGREEMENT BETWEEN USBHPC AND THE EMPLOYER GROUP MUST BE CONSULTED TO DETERMINE THE

EXACT TERMS AND CONDITIONS OF COVERAGE. A COPY OF THE GROUP SUBSCRIBER AGREEMENT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT USBHPC AND YOUR EMPLOYER GROUP'S PERSONNEL OFFICE.

NONDISCRIMINATION NOTICE AND ACCESS TO COMMUNICATION SERVICES

LANGUAGE ASSISTANCE SERVICES

We provide free auxiliary aids and language services. We provide free services to help you communicate with us. Such as, letters in other languages or in other formats like large print. Or, you can ask for an interpreter at no charge. To ask for help, please call 800-888-2998, Monday through Friday, 8 a.m. to 8 p.m. ET.

NOTICE OF NON-DISCRIMINATION

We do not treat members differently because of sex, age, race, color, disability, national origin, ancestry, religion, marital status, gender, gender identity, or sexual orientation.

If you think you were treated unfairly because of your sex, age, race, color, disability, national origin, ancestry, religion, marital status, gender, gender identity, or sexual orientation you can send a complaint to:

Optum Civil Rights Coordinator
11000 Optum Circle
Eden Prairie, MN 55344
Email: Optum_Civil_Rights@Optum.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call 800-888-2998, Monday through Friday, 8 a.m. to 8 p.m.

In cases of discrimination based on race, color, national origin, age, disability or sex, you can also file a complaint with the U.S. Dept. of Health and Human services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201