

STATE OF OHIO

Behavioral Health Benefits

Effective July 2011

Administered By



A United HealthCare Company

Table of Contents

Certification	1
Schedule of Benefits	2
Effective Date of this Plan.....	2
Eligibility	3
Eligible Employees.....	3
Eligible Dependents	3
Qualified Medical Child Support Order	3
Special Provision for Newborn Children	3
Behavioral Health Benefits	3
What This Plan Pays	3
Notification Requirements and Utilization Review	4
Emergency Care.....	4
Copayments.....	6
Maximum Benefit.....	6
What's Not Covered - Exclusions	6
Network Provider Charges Not Covered	8
Claims Information	8
How to File a Claim.....	9
When Claims Must be Filed.....	10
How and When Claims Are Paid	10
Benefit Determinations	10
Appeal Process.....	12
Legal Actions	14
Incontestability of Coverage.....	14
Information and Records	14
Coordination of Benefits	14
Definitions	14
How Coordination Works.....	14
Which Plan Pays First.....	15
Right of Recovery	16
Recovery Provisions	16
Refund of Overpayments.....	16
Reimbursement of Benefits Paid	16
Subrogation.....	17
Effect of Medicare and Government Plans	18
Medicare	18
Government Plans (other than Medicare and Medicaid)	19

Termination of Coverage	19
Employee Coverage.....	19
Dependent Coverage	20
Glossary	21

Certification

**Plan Description
for Employees of
State of Ohio
(called the Employer)
Group Policy No. GA 00832**

This is a Covered Person's Plan Description only while that person is covered under the policy. Dependents benefits apply only if the Employee is enrolled under the Employer's Plan for Dependent Benefits.

This Plan Description describes the Plan in effect as of July 1, 2011.

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

The behavioral health benefits described in this Plan are administered by United Behavioral Health.

1-800-852-1091

Schedule of Benefits

Effective Date of this Plan: July 1, 2011

Behavioral Health Benefits

Behavioral Health Benefit Plan Design Effective July 1, 2011	
Administered by United Behavioral Health 1-800-852-1091	
COPAYMENTS	
Outpatient in-network	\$20
Outpatient out-of-network	\$30; balance billing applies
Emergency Room	\$75
Intensive outpatient care in-network	\$20
Intensive outpatient care out-of-network	\$30; balance billing applies
DEDUCTIBLES	
Single in-network	\$200 combined with medical
Family in-network	\$400 combined with medical
Single out-of-network	\$400 combined with medical
Family out-of-network	\$800 combined with medical
PLAN COINSURANCE %	
Outpatient in-network	100% after office visit copay; 80% for some services
Outpatient out-of-network	60% of fee schedule after copayment. Balance billing applies
Inpatient in-network	80% after deductible. Preauthorization required
Inpatient out-of-network	60% of fee schedule after deductible. \$350 penalty if not preauthorized
OUT-OF-POCKET MAXIMUM	
Single in-network	\$1,500 combined with medical
Family in-network	\$3,000 combined with medical
Single out-of-network	\$3,000 combined with medical
Family out-of-network	\$6,000 combined with medical
OTHER	
Day Limits	None
Annual Limits	None
Lifetime Limits	None
Benefit Limits	Some

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

Eligibility

Eligible Employees and Dependents

All Employees of the Employer and their dependents who are enrolled in a health plan.

Effective Date of Employee and Dependent Coverage

Please refer to das.ohio.gov/qualifyingevents for a detailed description of the State of Ohio employee and dependent eligibility requirements. If you or your dependents qualify under under, and are enrolled in, a state sponsored medical plan, then you and your dependents are automatically enrolled for behavioral health care benefits.

Qualified Medical Child Support Order

If an Employee is required by a qualified medical child support order, as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for his/her children, these children can be enrolled as timely enrollees as required by OBRA 93.

If the Employee is not already enrolled, the Employee must enroll as a timely enrollee at the same time.

Plan Benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child.

Special Provision for Newborn Children

Plan Benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child.

Behavioral Health Benefits

What This Plan Pays

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

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

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

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

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

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

Behavioral Health Services are services and supplies which are:

- Covered Services, for MHSA Treatment.
- Given while the Covered Person is covered under this Plan.
- Given by one of the following providers:
 - Physician.
 - Psychologist.
 - Licensed Counselor.
 - Provider.
 - Hospital.
 - Treatment Center.

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

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

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

Notification Requirements and Utilization Review

To receive benefits under this Plan, the Covered Person should call United Behavioral Health (UBH) before inpatient and outpatient Behavioral Health Services are given. This is not required, however it helps ensure that the Covered Person receives the highest level of benefits. **The toll-free number is 1-800-852-1091. UBH is ready to take the Covered Person's call 7 days a week, 24 hours a day.** The Covered Person will be referred to a Network Provider who is experienced in addressing his/her specific issues.

If the Covered Person is not satisfied with a Network Provider, he/she may call UBH and ask for a referral to another Network Provider. An out-of-network benefit is available, however out-of-network providers have not been screened by UBH and your out-of-pocket costs for services will be higher.

For some services, UBH performs a Utilization Review to determine whether the service or supply is a Covered Service. The Covered Person and his/her Provider decide which Behavioral Health Services are given.

Emergency Care

Emergency Care does not require a referral from UBH to a UBH Network Provider. Emergency services are typically covered by your medical plan.

When Emergency Care is required for MHSA Treatment, the Covered Person (or his/her representative or his/her Provider) should call UBH within one day after the Emergency Care is given to report an admission or arrange for follow up care.. If it is not reasonably possible to make this call within one calendar day, the call

should be made as soon as reasonably possible.

Cost Sharing

Before some behavioral health benefits are payable, each Covered Person must satisfy certain Deductible Amounts and/or Copayments.

A Deductible is the amount you must pay before your plan starts to pay for benefits (except for routine office visits). Your deductible amount may accumulate from paying for medical expenses, behavioral health expenses, or a combination of both.

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

The amount of each Deductible and Copayment is shown in the **Schedule of Benefits**.

Office Visit Copayment

The Office Visit Copayment applies to services given by a Network or Non Network Provider. It applies to all services and supplies given in connection with each office visit.

Inpatient Copayment

The Inpatient Copayment or Coinsurance applies to services given in a Network or Non Network Provider Facility.

Intermediate Care Copayment

The Intermediate Care Copayment applies to services given by a Network or Non Network Provider. It applies to treatment in a hospital (for partial hospitalization) or to a Residential, Day or Structured Outpatient Treatment Facility.

Maximum Benefit

There are no maximum benefit limitations under the Plan.

What's Not Covered - Exclusions

The following exclusions apply regardless of whether the services, supplies, or treatment described in this section are recommended or prescribed by the Covered Person's Provider and/or the only available treatment options for the Covered Person's condition.

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

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

- Prescription drugs or over the counter drugs and treatments. (Refer to your prescription drug plan to determine whether prescription drugs are a covered benefit.)
- Services or supplies for MHSA Treatment that, in the reasonable judgment of UBH are any of the following:
 - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
 - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
 - not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;
 - typically do not result in outcomes demonstrably better than other available treatment alternative that are less intensive or more cost effective; or
 - not consistent with UBH's Level of Care Guidelines or best practices as modified from time to time.

UBH may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.

- Treatment or services, except for the initial diagnoses, for a primary diagnosis of Mental Retardation (317,318,319), Learning, Motor Skills, and Communication Disorders (315), Pervasive Developmental Disorder (299), Conduct Disorder (312), Dementia (290, 294), Sexual, Paraphilia, and Gender Identity Disorders (302), and Personality Disorders (301), as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by UBH.
- Unproven, Investigational or Experimental Services. Services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a Covered Service if the service, treatment, or device is considered to be unproven, investigational, or experimental.
- Custodial Care except for the acute stabilization of the Covered Person and returning the Covered Person back to his or her baseline levels of individual functioning. Care is determined to be custodial when:
 - it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the Covered Person's competent functioning in activities of daily living; or
 - it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the Covered Person to function outside a structured environment. This applies to Covered Persons for whom there is little expectation of improvement in spite of any and all treatment attempts.
- Covered Persons whose repeated and volitional non-compliance with treatment recommendations result in a situation in which there can be no reasonable expectation of a successful outcome.
- Neuropsychological testing when used for the diagnosis of attention deficit disorder.

Examinations or treatment, unless it otherwise qualifies as Behavioral Health Services, when:

- required solely for purposes of career, education, sports or camp, travel, employment, insurance or adoption;
- ordered by a court except as required by law;
- conducted for purposes of medical research; or
- required to obtain or maintain a license of any type.

- Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Nutritional Counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.
- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment rendered by unlicensed Providers, including pastoral counselors (except as required by law), or which are outside the scope of the Providers' licensure.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
- Light boxes and other equipment including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while confined in a facility.
- Surgical procedures including but not limited to sex transformation operations.
- Smoking cessation related services and supplies.
- Travel or transportation expenses unless UBH has requested and arranged for Covered Person to be transferred by ambulance from one facility to another.
- Services performed by a Provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the Provider may perform on himself or herself.
- Services performed by a Provider with the same legal residence as the Covered Person.
- Behavioral Health Services for which the Covered Person has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- Charges in excess of any specified Plan limitations.
- Any charges for missed appointments.
- Any charges for record processing except as required by law.
- Services Provided Under Another Plan. Services or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes but is not limited to coverage required by workers' compensation, no-fault auto, or similar legislation. If coverage under workers' compensation or a similar law is optional for Covered Person because Covered Person could elect it or could have it elected for him or her, benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected.
- Behavioral Health Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country when Covered Person is legally entitled to other coverage.

- Treatment or services received prior to Covered Person being eligible for coverage under the Plan or after the date the Covered Person's coverage under the Plan ends.

Network Provider Charges Not Covered

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

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

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

Non Network Provider Charges

If your medical plan provides out-of-network benefits, then you may have access to out-of-network benefits through United Behavioral Health, but at a higher cost to you. You should contact UBH before receiving services to ensure the highest level of benefits.

Penalty for Failure to Authorize an Out of Network Inpatient Stay

If your plan provides a benefit for out of network inpatient services, you must obtain pre-authorization before obtaining care. If you do not, you must pay a \$350 penalty.

Claims Information

How to File a Claim

A claim form does not need to be filed when a Network Provider is used. However, if the covered Employee should receive a bill the following steps should be completed:

The following steps should be completed when submitting bills for payment:

- Get a claim form from the Employer, the Plan Administrator or United Behavioral Health.
- Complete the Employee portion of the form.
- Have the Provider complete the Provider portion of the form.
- Send the form and bills to the address shown on the form.

Make sure the bills and the form include the following information:

- The Employee's name and social security number.
- The Employer's name and contract number (00832).
- The patient's name.

- The diagnosis.
- The date the services or supplies were incurred.
- The specific services or supplies provided.

If the covered Employee asks for a claim form but does not receive it within 15 days, the covered Employee can file a claim without it by sending the bills with a letter, including all of the information listed above.

Where to File a Claim

UBH Claim Appeal

P.O. Box 30760

Salt Lake City, UT 84130-0760

When Claims Must be Filed

The covered Employee must give UBH written proof of loss within 15 months after the date the expenses are incurred.

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

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

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

How and When Claims Are Paid

UBH will pay benefits directly to the Network Provider as soon as UBH receives satisfactory proof of loss, however, benefits will be paid to the covered Employee if he or she has submitted the claim form directly to UBH.

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

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

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

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

Benefit Determinations

Pre-service Claims

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

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the request to extend the treatment is an urgent claim as defined below, the Covered Person's request will be decided upon within 24 hours, provided the request is made at least 24 hours prior to the end of the approved treatment. UBH will make a determination on the request for the extended treatment within 24 hours from receipt of the request. If the request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent claim and decided according to the timeframes described below.

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

Post-service Claims

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

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

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

Urgent Claims that Require Immediate Attention

Urgent claims are those Emergency Care claims that require notification or a benefit determination prior to receiving Mental Disorder Treatment. In these situations:

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

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

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

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

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

Questions or Concerns about Benefit Determinations

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

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

State of Ohio Member Appeal Rights and Instructions

Your Rights to an Appeal Review

You, an authorized representative, or your treating provider acting on your behalf has the right to request an appeal review of the decision made by United Behavioral Health (UBH). You may request an appeal either verbally or in writing by following the steps below.

You have the right to file an urgent or non-urgent appeal. An urgent appeal can be requested if a delay in treatment places your health or the health of others in serious jeopardy, significantly increases the risk to your health, results in severe pain, or impacts your ability to regain maximum functioning.

If you have questions after reviewing the following information, please call. 1-800-852-1091.

How to Initiate an Internal Appeal Review through UBH

You may initiate your appeal in writing or verbally by contacting UBH at the address or toll free telephone number listed below.

United Behavioral Health
Appeals Department
P.O. Box 411517
St. Louis, MO 63141-3517

Toll Free Telephone: 1-866-859-0505
Fax Number: 1-800-290-9317

Your appeal request should include the following:

- Your name and identification number from your ID card.
- The date(s) of service(s).
- Your treating provider's name.
- Any additional information you would like to be considered as part of the appeal process. Examples of such information are: records relating to the current conditions of treatment, co-existent conditions, or any other relevant information.

For clinical cases, a board certified physician in the same or similar specialty area as your treating physician will review and make the decision about your appeal request. If your treating provider is not a physician, a doctoral-level psychologist or a physician will review and make a decision about your appeal request. The UBH physician or psychologist will not have had any previous involvement in decisions about your case.

The First Level Internal Appeal Review Process

Non-Urgent Process

You must request an appeal within one hundred eighty (180) calendar days of the date you received your adverse determination letter from UBH. UBH will notify you or your authorized representative and your health care provider of the appeal resolution in writing within thirty (30) calendar days of the receipt of your request. If this is an appeal of services you have not yet received, UBH will complete the review and notify you of the outcome within fifteen (15) calendar days of the receipt of your request.

Urgent Process

If a delay in treatment places your health or the health of others in serious jeopardy, significantly increases the risk to your health, results in severe pain, or impacts your ability to regain maximum function you can request an urgent appeal. You or your provider should call UBH as soon as possible using the phone number listed above. An urgent appeal will be reviewed, a decision made, and you and your provider notified within seventy-two (72) hours of the receipt of your request.

The Second Level Internal Appeal Review Process (Non-Urgent Process)

If your first level appeal request was a non-urgent review, and you remain dissatisfied with the outcome of that review, you may request a second level non-urgent appeal. This request must be made within sixty (60) calendar days of the date you received notification from UBH of the outcome of your first level appeal. To request a second level non-urgent appeal, contact your employer at the address listed below. Your employer will notify you or your authorized representative and your health care provider of the appeal resolution in writing within thirty (30) calendar days of the receipt of your request. If this is an appeal of services you have not yet received, your employer will complete the review and notify you of the outcome within fifteen (15) calendar days of the receipt of your request.

United Behavioral Health
Appeals Department
P.O. Box 411517
St. Louis, MO 63141-3517

Toll Free Telephone: 1-866-859-0505
Fax Number: 1-800-290-9317

How to Initiate a Third Level Review

If both levels of appeal have been exhausted and you disagree with the decision, you can request a third level benefit determination. You may submit a written request within 60 days of receiving United Behavioral Health's final written decision and supply the documentation from earlier appeals. Send your request and documentation to:

Behavioral Health Benefit Appeal
United Behavioral Health
Appeals Department
P.O. Box 411517
St. Louis, MO 63141-3517

Toll Free Telephone: 1-866-859-0505
Fax Number: 1-800-290-9317

A written decision will be given as quickly as possible, but no longer than 60 days after you submit your request

Additional Rights

You may request, free of charge, a paper copy of any relevant documents, records, guidelines or other information UBH used to make its decision. To request a copy of this information, contact UBH at the address or telephone number on page 1 of this document. Some information will require a written request or consent from the member before it can be released.

Legal Actions

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

Incontestability of Coverage

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

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

Information and Records

At times we may need additional information from you. The Covered Person must agree to furnish United Behavioral Health with all information and proofs that we may reasonably require regarding any matters pertaining to the Policy. If the Covered Person does not provide this information when we request it we may delay or deny payment of Benefits.

By accepting the Behavioral Health Services under the Policy, you authorize and direct any person or institution that has provided services to you to furnish UBH with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Dependents whether or not they have signed the Employee enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or

as UBH is required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes.

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

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

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

Coordination of Benefits

Coordination of benefits applies when a covered Employee or a covered Dependent have health coverage under this Plan and one or more Other Plans.

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

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

Definitions

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

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

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

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

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

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

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

How Coordination Works

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

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

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

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

Which Plan Pays First

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

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

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

If the other plan does not have a birthday rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the plan of the parent with custody for the child.
 - Second, the plan of the spouse of the parent with the custody of the child.
 - Finally, the plan of the parent not having custody of the child.

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

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
- The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same rule applies if a person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

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

Right of Recovery

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

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

Recovery Provisions

Refund of Overpayments

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

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

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

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

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

Reimbursement of Benefits Paid

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, UBH may reduce the amount of any future benefits that are payable under this Plan. UBH may

also reduce future benefits under any other group benefits plan administered by UBH for the Employer. The reductions will equal the amount of the required refund. UBH may have other rights in addition to the right to reduce future benefits.

Subrogation

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

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

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

Effect of Medicare and Government Plans

Medicare

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

When This Plan Pays Primary to Medicare

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

- Eligibility for Medicare is due to age 65 and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to disability and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD) under the conditions and for the time periods specified by federal law.

When Medicare Pays Primary to this Plan

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

- The employee is a Retired Employee.
- Eligibility is due to disability and the Employee does NOT have "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary.

See How this Plan Pays When Medicare is Primary.

Important! - Medicare Enrollment Requirements

When this Plan pays benefits first, without regard to Medicare, and the Covered Person wants Medicare to

pay after this Plan, the Covered Person must enroll for Medicare Parts A and B. If the Covered Person does not enroll for Medicare when he or she is first eligible, the Covered Person must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Plan.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under this Plan, whether or not the person has enrolled for Medicare. If Medicare pays first, the Covered Person should enroll for both Parts A and B of Medicare when that Covered Person is first eligible; otherwise, the expenses may not be covered by the Plan or Medicare.

How This Plan Pays When Medicare Is Primary

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

If the Provider has agreed to limit charges for services and supplies to the charges allowed by Medicare (participating physicians), this Plan determines the amount of Covered Expenses based on the amount of charges allowed by Medicare.

If the Provider has not agreed to limit charges for services and supplies to the charges allowed by Medicare (non-participating physicians), this Plan determines the amount of Covered Expenses based on the lesser of the following:

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

This Plan determines the amount payable without regard to Medicare benefits. Then this Plan subtracts the amount payable under Medicare for the same expenses from Plan benefits. This Plan pays only the difference between Plan benefits and Medicare benefits.

The amount payable under Medicare which is subtracted from this Plan's benefits is determined as the amount that **would have been payable to a Medicare eligible covered under Medicare even if:**

- The person is not enrolled for Medicare Parts A and B. Benefits are determined as if the person were covered under Medicare Parts A and B.
- The expenses are paid under another employer's group health plan which is primary to Medicare. Benefits are determined as if benefits under that other employer's plan did not exist.
- The person is enrolled in a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) to receive Medicare benefits, and receives unauthorized services (out-of-plan services not covered by the HMO/CMP). Benefits are determined as if the services were authorized and covered by the HMO/CMP.

Government Plans (other than Medicare and Medicaid)

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

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

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

Termination of Coverage

Employee Coverage

Employee coverage ends on the earliest of the following:

- The day this Plan ends.
- The end of the month for which contributions for the cost of coverage have been made after employment stops. See **Disability** and **Leave of Absence or Temporary Layoff** below.
- The last day of a period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made when due.

Disability

The Employer has the right to continue a person's employment and coverage under this Plan during a period in which the person is away from work due to disability. The period of continuation is determined by the Employer based on the Employer's general practice for an Employee in the person's job class.

Coverage ends on the date the Employer notifies UBH that the person's employment has stopped and coverage is to be ended.

Leave of Absence or Temporary Layoff

The Employer has the right to continue the person's employment and coverage under this Plan during a period in which the person is away from work due to an approved leave of absence or temporary layoff. The period of continuation is determined by the Employer based on the Employer's general practice for an Employee in the person's job class.

Coverage will end on the last day of the month following the month in which the layoff begins. An Employee on a leave of absence has the option of making direct premium payments to the Employer.

Dependent Coverage

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

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

Coverage for an individual Dependent ends on the earlier of:

- The day the Dependent becomes covered as an Employee under this Plan.
- The last day of the month in which the Dependent stops being an eligible Dependent.

Continuation of Coverage for Incapacitated Children

A mentally or physically incapacitated child's coverage will not end due to age. It will continue as long as Dependents coverage under this Plan continues and the child continues to meet the following conditions:

- The child is incapacitated.
- The child is not capable of self-support.
- The child depends mainly on the Employee for support.

The Employee must give UBH proof that the child meets these conditions when requested. UBH will not ask for proof more than once a year. If extended coverage has been approved by your medical plan, then it also applies to this plan.

Glossary

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

Behavioral Health Services

Services and supplies which are:

- Covered Services for MHSA Treatment.
- Given while the Covered Person is covered under the plan.
- Given by one of the following providers:
 - Physician.
 - Psychologist.
 - Licensed Counselor.
 - Provider.
 - Hospital.
 - Treatment Center.
- Behavioral Health Services include but are not limited to the following:
 - Assessment.
 - Diagnosis.
 - Treatment Planning.
 - Medication Management.
 - Individual, family and group psychotherapy.
 - Psychological testing if clinically necessary

Covered Expenses

The actual cost to the Covered Person of the Reasonable Charge for Behavioral Health Services given.

Covered Person

The Employee and the Employee's wife or husband and/or Dependent children who are covered under this Plan.

Course of Treatment

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

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

Covered Services

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

Emergency Care

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

Employee

A person on the payroll of the Employer who is enrolled in a State sponsored health care plan.

Fiscal Year

A period of one year beginning with July 1 and ending with a June 30.

Hospital

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

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

Licensed Counselor

A person who specializes in MHSA Treatment and is licensed as a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW) by the appropriate authority.

Medicare

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

MHSA Treatment

MHSA Treatment is mental health and/or substance abuse treatment for the following:

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

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

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

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

Prescription Drugs are not considered Mental Disorder Treatment.

Network Provider

A Provider which participates in the United Behavioral Health network.

Non-Network Provider

A Provider which does not participate in the United Behavioral Health network.

Physician

A legally qualified:

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

Plan

The group policy or policies which provide the benefits described in this Plan Description..

Provider

A person who is qualified and duly licensed or certified by the state in which he or she is located to furnish MHSA Treatment.

Psychologist

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

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

Reasonable Charge

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

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

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

Total Disability or Totally Disabled

- An Employee's inability to perform all of the substantial and material duties of his or her regular employment or occupation.
- A Dependent's inability to perform the normal activities of a person of like age and sex.

Treatment Center

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

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

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

Utilization Review

A review and determination as to services and supplies are Covered Services.
