PacifiCare®
Behavioral Health

Helping you navigate life's challenges

Summary Plan Description

University of California
Los Alamos National Laboratory

Options PPO National and Options PPO Out-of-Area Plans

Table of Contents

Introduction 2
Schedule of Behavioral Health Benefits 3
Eligibility 4
- No Dual Coverage 5

Enrollment 6
- During a Period of Initial Eligibility 6
- At Other Times for Employees and Retirees 6
- Effective Date 7
- Change in Coverage 7
- Effect of Medicare on Enrollment 7
- Medicare Secondary Payer Law 8
- Medicare Private Contracting Provision 8

Benefits and Conditions for Coverage 8
Member Obligations 8
- Pre-Authorization for Behavioral Health Services 8
- Eligibility for In-Area Benefits 8
- Concurrent Review of Behavioral Health Services 9
- Reduction in Benefits for Failure to Complete an Inpatient Treatment Program 9
- Copayments 9
- Payment for Non-Covered Services 9
- Emergency Treatment and Urgently Needed Services 9
- Continuing or Follow-Up Treatment 9

Acts Beyond the Control of the Plan Sponsor for PBHI 10
Questions and Complaints 10
Appeals Procedure 10
- Level 1 Initial Informal Review 10
- Level 2 Appealing an Informal Review Decision 10
- Level 3 Independent Medical Review 11
- Level 4 Binding Arbitration 11

Expedited Review Process 12
Member Claims Against Participating Practitioners and Facilities 12
Termination of Coverage 12
- Disenrollment Due to Loss of Eligible Status 12
- Disenrollment Due to Fraud 12
- Leave of Absence, Layoff or Retirement 12
- Optional Continuation of Coverage 12

PBHI Nonliability After Termination 13
Third Party Liability 13
Non-duplication of Benefits/Coordination of Benefits 13
- Workers' Compensation Insurance 14
- Medicare Benefits 14
- Automobile, Accident, or Liability Coverage 14
- Coordination of Benefits (COB) 14
- Right to Receive and Release Necessary Information 15
- Facility of Payment 16
- Right of Recovery 16

Covered Services 16
- Cost Control Reduction 17

Exclusions 17
Miscellaneous Provisions 20
- Plan Administration 20
- Sponsorship and Administration of the Plan 20
- Group Contract Number 20
- Type of Plan 21
- Plan Year 21
- Continuation of the Plan 21
- Financial Arrangements 21
- Agent for Serving of Legal Process 21
- Your Rights Under the Plan 21
- Claims Under the Plan 21
- Nondiscrimination Statement 21
- Amendments 21
- Notice 21

Definitions 22

Introduction

This *Summary Plan Description* describes the terms and conditions of coverage under your Employee Behavioral Health Benefits Plan ("Plan"). Read this document carefully so that you will have a clear understanding of your Coverage under this Plan. If you have any questions regarding your Coverage or procedures for obtaining Behavioral Health Services, you may call PacifiCare Behavioral Health, Inc. ("PBHI") at 1-800-817-8811. PBHI has entered into an agreement with the University of California ("Plan Sponsor") to provide certain administrative services related to Coverage under this Plan, including but not limited to premium billing and collection, claims payment, case management, pre-authorization and provider access.

All Behavioral Health Services, other than Emergency Treatment and Urgently Needed Services, are subject to prior authorization by PBHI, as described in this *Summary Plan Description*.

Only Medically Necessary Behavioral Health Services are covered under this Plan. PBHI has sole and exclusive discretion in interpreting the benefits covered under this Plan and the other terms, conditions, limitations and exclusions set out in the Administrative Services Agreement and this *Summary Plan Description*. Plan Sponsor reserves the right to change, interpret, modify, withdraw or add benefits or terminate this Plan, in its sole discretion, without prior notice or approval by Plan participants. The legal documents governing this Plan consist of only the Administrative Services Agreement, along with this *Summary Plan Description* and the *Schedule of Behavioral Health Benefits*. Any change or amendment to this Plan, its benefits or its terms and conditions may be made solely in written amendment to this Plan, approved by the Plan Sponsor. No person or entity has any authority to make any oral changes or amendments to this Plan.

PacifiCare Behavioral Health, Inc.
3120 Lake Center Drive
Santa Ana, California 92704-6917

Or visit the website: www.pbhi.com

Customer Service
1-800-817-8811
1-888-877-5378 (TDHI)

Schedule of Behavioral Health Benefits

UNIVERSITY OF CALIFORNIA
LOS ALAMOS
NATIONAL LABORATORY

Options PPO National and Options PPO Out-of-Area Plans Schedule of Benefits

The Calendar Year Deductible, benefits maximums, benefit level, and lifetime maximums are combined for a member who transfers between the United Healthcare Plans.

Mental Health Services

	Benefits
Maximum Inpatient Benefit, Per Member Per Lifetime	None
Calendar Year Deductible Amount	$250
Inpatient, Residential and Day Treatment	Based on Medical Necessity
Coverage Level	90%
Outpatient Treatment	Based on Medical Necessity
Note: A separate $3,000 per Member/ $9,000 per family out-of-pocket maximum applies to all Mental Health PPO benefits.	

Chemical Dependency Rehabilitation

	Benefits
Maximum Inpatient Benefit, Per Member Per Lifetime	130 days[1] (Combined with Chemical Detoxification)
Calendar Year Maximum Benefit	$10,000
Inpatient, Residential and Day Treatment *(Combined with Chemical Detoxification)*	1 treatment episode per Calendar Year[2]
Days to be determined based on the following levels of care	
Inpatient	1 day
Residential Treatment	7/10 of 1 day
Day Treatment	6/10 of 1 day
Calendar Year Deductible Amount	$250
Coverage Level *(Waived for detoxification and outpatient treatment)*	80%
Non-Compliance Reduction (*Percentage by which a Member's coverage level is reduced when Member leaves the Chemical Dependency Inpatient, Residential Treatment or Day Treatment program against the medical advice of a PBHI Participating Provider)*	30%
Outpatient Treatment	$3,500 per Calendar Year
Coverage Level	80%

Chemical Detoxification

	Benefits
Maximum Inpatient Benefit, Per Member Per Lifetime	130 days[1] (Combined with Chemical Dependency)
Calendar Year Maximum Benefit	$10,000
Maximum Benefit, Per Member, Per Calendar Year (*Combined with Chemical Dependency)*	1 treatment episode per Calendar Year[2]
Calendar Year Deductible Amount (*Combined with Chemical Dependency)*	$250
Coverage Level	80%

All Mental Health, Chemical Dependency, and Detoxification treatment must be Pre-Authorized by PBHI toll free at 1-800-817-8877. The number of visits, days or episodes authorized must be Medically Necessary.

[1] For purposes of determining the number of treatment days for the maximum Inpatient benefit, Residential Treatment days are counted as 70 percent of one day and Day Treatment days are counted as 60 percent of one day. This permits the Member to obtain additional coverage when alternate levels of care are utilized. Number of days are determined by clinical appropriateness under the Plan's guidelines for Medical Necessity.

[2] Length of treatment episode(s) is (are) determined by clinical appropriateness under the Plan's guidelines for Medical Necessity.

The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations"), and any corresponding Administrative Supplements. Portions of these Regulations are summarized in this Summary Plan Description.

Eligibility

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO), Point-of-Service (POS) or Exclusive Provider Organization (EPO) Plan, they are only eligible to enroll in the plan if they meet the Plan's geographic service area criteria. Anyone enrolled in a non-University Medicare Advantage Managed Care contract is not eligible for this plan.

Subscriber

Employee: You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000* hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

* Lecturers - see your benefits office for eligibility.

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

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

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

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

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

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

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

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan, or as a **Survivor** when you start collecting survivor benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

(a) you meet the University's service credit requirements for Retiree medical eligibility;

(b) the effective date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the Employee/Retiree's death for a Survivor); and

(c) you elect to continue medical coverage at the time of retirement.

If you are eligible for Medicare, see "Effect of Medicare on Retiree Enrollment" below.

Eligible Dependents (Family Members): When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member

meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return, or other official documentation.

Spouse: Your legal spouse.

Child: All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

(a) your natural or legally adopted children;

(b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;

(c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;

(d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental handicap may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;
- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and
- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

Other Eligible Dependents (Family Members): You may enroll a same-sex domestic partner (and the same-sex domestic partner's children/grandchildren/stepchildren) as set forth in the University of California Group Insurance Regulations.

Effective January 1, 2005, the University will recognize an opposite sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and domestic partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage effective January 1, 2004. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans.

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member, but not under any combination of these. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll

separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

Enrollment

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan you are enrolled in.

(a) For a spouse, on the date of marriage.

(b) For a natural child, on the child's date of birth.

(c) For an adopted child, the earlier of:

    (i) the date you or your Spouse has the legal right to control the child's health care, or

    (ii) the date the child is placed in your physical custody.

    If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

(d) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other group medical plan coverage and you lose that coverage involuntarily, you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

If you are in an HMO, POS or PPO Plan and you move or are transferred out of that plan's service area, or will be away from the plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the plan's service area.

At Other Times For Employees And Retirees

You and your eligible Family Members may also enroll during a group open enrollment period established by the University.

If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan you were enrolled in immediately before

retiring. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin).

If you are a Survivor, you may not enroll your legal spouse or domestic partner.

Effective Date

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

(a) the date Child becomes eligible, or

(b) a maximum of 60 days prior to the date your Child's enrollment transaction is completed.

Change in Coverage

In order to change from single to adult plus child(ren) coverage, or two adult coverage, or family coverage, or to add another Child to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's non-University employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan. Beginning January 1, 2004, Retirees or their Family Members who become eligible for premium free Medicare Part A and do not enroll in Part B, will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium free Medicare Part A, but declined to enroll in Part B of Medicare before January 1, 2004, were assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B. Retirees or Family Members who are not eligible for premium free Part A will not be assessed an offset fee nor lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium free Medicare Part A will not be required to enroll in Part B.)

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how you enroll in the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration forms are available through the University's Customer Service Center. Completed forms should be returned to University of California, Human Resources and Benefits, Health and

Welfare Administration-Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-9911.

An individual enrolled in a University-sponsored Medicare Advantage Managed Care contract must assign his/her Medicare benefits to that plan or lose UC-sponsored medical coverage.

Medicare Secondary Payer (MSP) Law

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. UC Retirees hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For Employees or their spouses who are age 65 or older and eligible for a group health plan due to employment, Medicare becomes the secondary payer and the employer plan becomes the primary payer.

Medicare Private Contracting Provision

Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services (that would otherwise be covered by Medicare) from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners requiring the beneficiary to be responsible for all payments to such providers. Services provided under "private contracts" are not covered by Medicare, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage) and enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement with one or more physicians or practitioners, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. No benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.

However, if you do sign a private contract with a physician or practitioner, you may see other physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.

Benefits and Conditions for Coverage

Subject to all terms, conditions, exclusions, and limitations set forth in this Plan, all eligible Members shall be entitled to the Behavioral Health Services and benefits described in this Plan.

Member Obligations

Member shall submit to PBHI for reimbursement any and all claims for Emergency Services and Urgently Needed Services received for covered Behavioral Health Services from a non-participating provider within ninety (90) days of the date of service if possible and in no event later than one (1) year from the date services are provided.

Pre-Authorization for Behavioral Health Services – Except for Emergency Treatment and Urgently Needed Services, all Behavioral Health Services received by a Member must be pre-authorized by a PBHI Clinician in order to qualify for coverage under this Plan. Members requiring Behavioral Health Services must call PBHI's 24-hour phone number identified herein to arrange for an appointment with a PBHI Clinician.

A PBHI Clinician will evaluate the nature and severity of the Member's problem for Medical Necessity. If treatment is determined Medically Necessary, the PBHI Clinician will recommend the most appropriate treatment for Member. The PBHI Clinician will contact the Participating Facility or Participating Practitioner regarding the initially authorized Behavioral Health Treatment Program. The PBHI Clinician will only authorize services, which are Medically Necessary for the treatment of Mental Disorders or Chemical Dependency. No benefits are paid for services provided without the prior authorization of the PBHI Clinician, unless such services are Urgently Needed or required because of an Emergency.

Eligibility for In-Area Benefit – The in-area status of the primary subscriber (employee, retiree, or survivor) determines whether the employee/retiree/survivor and dependent receive in-area behavioral

health benefits. However, in-area
members who live or travel outside the United States receive emergency PBHI benefits only.

Concurrent Review of Behavioral Health Services – Member shall cooperate with PBHI's concurrent reviews of Behavioral Health Services which shall be conducted on a regular basis throughout a Member's Behavioral Health Treatment Program to ensure the effectiveness and appropriateness of the level of care, and to determine the necessity of a continuous stay and/or treatment. The PBHI Clinician must authorize all extended lengths of stay and transfers to different levels of care as well as any related additional services.

Reduction in Benefits for Failure to Complete an Inpatient Treatment Program – In order to receive the maximum benefits under this Plan for a specific Chemical Dependency Inpatient Treatment Program, the Member must complete the entire Chemical Dependency Inpatient Treatment Program. If Member abandons a Chemical Dependency Inpatient Treatment Program prior to the scheduled discharge or transfer authorized by the PBHI Clinician, coverage for the Chemical Dependency Inpatient Treatment Program under this Plan shall be reduced by thirty percent (30%). Member shall be required to reimburse the Participating Practitioner or Participating Facility for this Copayment.

Copayments – Copayments, when applicable, are an obligation of the Member at the time services are rendered. Failure to pay a Copayment may result in termination of Member's Coverage under this Plan. A schedule of the applicable Copayments for services rendered to Member is set forth in the *Schedule of Behavioral Health Benefits*.

Payment for Non-Covered Services – Nothing in this Plan shall prevent the Plan or the Participating Practitioner from collecting Prevailing Rates from the Member for non-covered services or for services rendered due to fraud or misrepresentation by Member.

Emergency Treatment and Urgently Needed Services – The cost of an Emergency Treatment and Urgently Needed Services shall be covered by this Plan if the following procedures are followed.

Procedure for Emergency Treatment and Urgently Needed Services

- If Member or someone acting on Member's behalf is unable to contact PBHI prior to going to a Facility for an Emergency Admission and Urgently Needed Services, Member or the person(s) acting on Member's behalf must notify or take reasonable steps to notify PBHI within twenty-four (24) hours or as soon as reasonably possible after the Emergency Treatment and Urgently Needed Services to inform PBHI of the location, duration and nature of the Emergency Treatment or Urgently Needed Services.
- If an Emergency Treatment or Urgently Needed Services are rendered at a Facility not designated by PBHI, Member or Member's representative should notify PBHI in writing as soon as possible of the nature and necessity of the Emergency Treatment and Urgently Needed Services and should attach any bills Member has received. Undisputed claims for Emergency Treatment and Urgently Needed Services shall be paid within thirty (30) working days of receipt of a properly completed claim.

Mail notification and bills to:

PacifiCare Behavioral Health, Inc.
Claims Department
P.O. Box 31053
Laguna Hills, CA 92654-1054

- Facility admissions for non-emergency or non-Urgently Needed Behavioral Health Services which have not been authorized by PBHI and visits to non-Participating Practitioner for non-emergency or non-Urgently Needed Behavioral Health Services which have not been authorized by PBHI are not covered under this Plan.

Continuing or Follow-Up Treatment – Continuing or follow-up treatment to an Emergency Treatment or for non-Urgently Needed Services must be coordinated through PBHI. PBHI will require the Member to transfer to a Participating Practitioner or Facility designated by PBHI, provided the transfer does not crate an unreasonable risk to the Member's health.

Acts Beyond the Control of the Plan Sponsor or PBHI

In the event of circumstances not reasonably within the control of the Plan Sponsor or PBHI, such as any major disaster, epidemic, complete or partial destruction of Facility, war, riot, or civil insurrection, which results in the unavailability of the Facilities, personnel or Participating Practitioners, the Plan Sponsor, PBHI, Participating Practitioner and Participating Facilities shall provide or attempt to arrange for Behavioral Health Services insofar as practical, according to their best judgment, with the limitation of such Facilities and personnel. Neither the Plan Sponsor nor PBHI nor any Participating Practitioner or Participating Facility shall have any liability or obligation for delay or failure to provide or arrange for Behavioral Health Services if such delay or failure is the result of any of the circumstances described above.

Questions and Complaints

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 PBHI Customer Service Department at 1-800-817-8811 for a resolution.

If you feel the situation has not been addressed to your satisfaction, you may submit a formal complaint within 180 days of your receipt of an initial determination over the telephone by calling the PBHI toll-free number. You can also file a complaint in writing:

PacifiCare Behavioral Health, Inc.
Post Office Box 55307
Sherman Oaks, CA 91413-0307
Attn: Appeals Department

Or at the PBHI website: www.pbhi.com

When a complaint is received either by telephone or in writing by a PBHI Member Service Associate, the following procedure will be followed in handling complaints under the Appeal Procedure:

The PBHI Member Service Associate shall document the complaint (received either by telephone or in writing), the date received and the name of the PBHI Member Service Associate recording the complaint. If the complaint is by telephone and the person taking the call is unable to resolve the problem to the Member's satisfaction, the Member will be asked to submit a written complaint. The PBHI Member Service Associate will assist the Member in filing a written complaint if the Member desires the assistance.

Appeals Procedure

All complaints are directed to the Quality Management Manager ("QM Manager"). The QM Manager mails an acknowledgment letter to the Member and/or the Member Representative within five business days of receipt of a verbal or written appeal request.

Level 1: Initial Informal Review

The Quality Management Manager assembles an appeal file, which includes all information received to this point in the process, and presents it to the clinical reviewer for a determination. Within five (5) business days of the determination being made, a PBHI Quality Management Manager mails written notification of the determination to the Member and/or Member Representative.

Level 2: Appealing an Informal Review Decision

If the Member and/or Member Representative receives an adverse determination to the initial appeal and would like to pursue the appeal further, he/she may initiate a second-level appeal either verbally or in writing to the address or phone number indicated above. The verbal or written second-level appeal must be initiated within forty-five 45 days of the date of the first-level written notification. Within 30 working days of the request, the file is presented to a panel assembled specifically for the review of the appeal for a determination. The Member has the option to appear before the panel either in person or via teleconference. The Member/ Member Representative will be notified via mail within five working days of the determination. If the determination is based in whole or in part on a finding that the service is/was not medically necessary, the written notification also provides information regarding the right to seek review by an Independent Review Organization (IRO).

Level 3: Independent Medical Review

If the Member is dissatisfied with the determination to deny, modify, or delay services is based in whole, or in part, on a finding that the disputed services are not medically necessary, the Member or Member Representative may request an Independent Medical Review (IMR). The request for IMR must be received by PBHI within six (6) months of: a) the enrollee's provider recommending a service as medically necessary; b) the enrollee receiving urgent care for emergency service that a provider determined was medically necessary; or c) the enrollee - without provider recommendation – has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review. The application deadline may be extended beyond the six (6) months if the circumstances of a case warrant the extension. Upon receipt of the determination by the IRO, PBHI promptly sends written notification the Member/Member Representative.

Level 4: Binding Arbitration

If the Member is dissatisfied with the appeal, the Member may submit or request that PBHI submit the appeal to binding arbitration before Judicial Arbitration and Mediation Service ("JAMS").

Any and all disputes of any kind whatsoever, including, claims for medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligent, or incompetently rendered), except for claims subject to ERISA, between Member (including any heirs, successor or assigns of Member) and PBHI, or any of its parents, subsidiaries or affiliates shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. Member and PBHI are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single arbitrator in accordance with the Comprehensive Arbitration Rules and Procedures of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor mutually to agree to the appointment of the arbitrator; but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Arbitration Rules and Procedures will be utilized.

Arbitration hearings shall be held in the county in which the Member lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration. The arbitrator selected shall have the power to control the timing, scope, and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Court of New Mexico including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by Federal and New Mexico law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, PBHI may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. Please contact PBHI for more information on how to obtain a hardship application.The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein. The Federal Arbitration Act, 9 U.S.C. SS 1-16, shall also apply to the arbitration.

BY ENROLLING IN PACIFICARE BEHAVIORAL HEALTH (PBHI) BOTH MEMBER (INCLUDING ANY HEIRS, SUCCESSOR OR ASSIGNS OF MEMBER) AND PBHI AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO A JURY TRIAL AND INSTEAD VOLUNTARILY AGREE TO THE USE OF BINDING ARBITRATION AS DESCRIBED IN THIS COMBINED

EVIDENCE OF COVERAGE AND DISCLOSURE FORM.

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 PBHI Medical Director for expedited review, regardless of whether such appeal is received orally or in writing. PBHI will provide the Member with written statement of the disposition or pending status of the expedited review no later than three (3) days from receipt of complaint.

Member Claims Against Participating Practitioners and Facilities

Member acknowledges that Participating Practitioners and Participating Facilities are independent contractors and that the Plan does not assume responsibility for the acts of the Participating Practitioners and Participating Facilities as the result of this independent contractor relationship.

Member claims for damages as the result of an injury caused or alleged to have been caused by an act or failure to act by Participating Practitioner, Participating Facility or other provider of Behavioral Health Services are not governed by this Plan. Member may seek any appropriate legal action against such persons and entities deemed necessary.

Termination of Coverage

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Disenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If you are a Retiree or Survivor and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on disenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Disenrollment Due to Fraud

Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be permanently disenrolled while any other Family Member and the Subscriber will be disenrolled for 18 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be disenrolled for 18 months.

Leave of Absence, Layoff or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Optional Continuation of Coverage

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law.
The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the University's "At Your Service" website (http://atyourservice.ucop.edu). The notice is also available from the person in your department who

handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are a Retiree.

PBHI Nonliability After Termination

PBHI shall have no further liability to provide benefits to any Member, including, without limitation, those Members who are inpatient in a Facility or are undergoing treatment for an ongoing condition after termination of this plan. Member's right to receive benefits hereunder shall cease upon the effective date of termination of this plan.

Third Party Liability

In the case of injuries caused by any act or omission of a third party, and any complications incident thereto, the benefits of this Plan shall be furnished to a Member. Member agrees, however, to reimburse this Plan, or its nominee, for the cost of all such benefits provided, at Prevailing Rates, immediately upon obtaining a monetary recovery, whether due to settlement or judgment, on account of such injury. Member shall hold any such sum in trust for this Plan, but said sum shall not exceed the lesser of, the amount of the recovery obtained by Member or the reasonable value of all such benefits furnished to the Member or on a Member's behalf by this Plan on account of such incident.

Member agrees that this Plan's rights to reimbursement are the first priority claim against any third party. This means that this Plan shall be reimbursed from any recovery before payment of any other existing claims, including any claim by the Member for general damages. This Plan may collect from the proceeds of any settlement or judgment recovered by the Member or his or her legal representative regardless of whether the Member has been fully compensated.

Member agrees to cooperate in protecting the interest of this Plan under this provision. Member must execute and deliver to PBHI any and all liens, assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the right of this Plan, including, but not limited to, the granting of a lien right in any claim or action made or filed on behalf of Member and the signing of documents evidencing same.

Member shall not settle any claim, or release any person from liability, without the written consent of PBHI, wherein such release or settlement will extinguish or act as a bar to this Plan's rights of reimbursement.

In the event PBHI employs an attorney for the purpose of enforcing any part of this Section against a Member based on Member's failure to cooperate with PBHI, the prevailing party in any legal action or proceeding shall be entitled to reasonable attorney's fees.

In lieu of payment as indicated above, PBHI, at its option may choose that this Plan be subrogated to the Member's rights to the extent of the benefits received under this Plan. This Plan's subrogation right shall include the right to bring suit in the Member's name. Member shall fully cooperate with PBHI when PBHI exercises this Plan's right of subrogation and Member shall not take any action or refuse to take any action which should prejudice the rights of this Plan.

Non-duplication of Benefits/ Coordination of Benefits

Workers' Compensation Insurance – PBHI will not cover services provided to you, which duplicate the benefits to which you are entitled under any applicable Workers' Compensation law. You are responsible for taking whatever action is necessary to obtain payment under Workers' Compensation laws where payment under that system can be reasonably expected. PBHI will not provide or arrange for benefits for a work-related illness 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.

In the event this Behavioral Health Plan provides benefits which duplicate the benefits to which you are entitled under Workers' Compensation law, you are required to reimburse PBHI, or its nominee, for the cost of all such services and benefits administered by PBHI, at prevailing rates, immediately upon obtaining a

monetary recovery whether by settlement or judgment.

In the event of a dispute arising between you and your Workers' Compensation coverage regarding your ability to collect under Workers' Compensation laws, PBHI may administer those behavioral health benefits described in this *Summary Plan Description* until the dispute is resolved if the Member signs an agreement to reimburse PBHI for 100% of the benefits provided.

You and your Family Members are required to cooperate in protecting the interest of this Behavioral Health Plan under this reimbursement provision by executing and delivering to PBHI or its nominee any and all liens, assignments or other documents.

Medicare Benefits – Member shall furnish information to PBHI concerning Member's eligibility for Medicare (Part A and/or Part B coverage) upon request by the Plan. In those instances set forth below, this Plan shall not furnish benefits, which duplicate the benefits to which Member is entitled as a Medicare beneficiary. Should the cost of Behavioral Health Services exceed the coverage of any applicable Medicare coverage, Plan benefits shall be provided over and above such coverage.

If payment is made by this Plan in duplication of the benefits available to Member as a Medicare beneficiary as set forth below, this Plan may seek reimbursement from the insurance carrier, provider, or Member up to the amount this Plan has paid for benefits which duplicate the Medicare coverage.

Plan is Primary – In the following instances, this Plan shall furnish benefits to Members with Medicare coverage, and Medicare shall be responsible for payment only to the extent the services provided to Member are not covered under this Plan:

Aged Employees – Subscribers actively employed age sixty-five (65) or older or any dependent age sixty-five (65) or older, unless the Subscriber or dependent elects to retain Medicare as his or her primary insurer;

- Disabled Employees. Members eligible for Medicare as the result of a disability;
- End-Stage Renal Disease Beneficiaries (Initial Period). Members entitled to Medicare solely on the basis of end-stage renal disease, beginning the earlier of:
  - the month in which the Member initiates a regular course of renal dialysis, or
  - the month in which an individual who receives a kidney transplant could become entitled to Medicare.

Medicare is Primary – In the following instances this Plan's coverage shall be limited to the costs of Behavioral Health Services which are not covered by Medicare:

- Medicare Retirees. Members who meet the definition of Medicare Retiree set forth in Medicare laws and regulations;
- Members Who Elect Medicare as Primary. Members for which this Plan would otherwise by primary, but who elect to have Medicare as their primary insurer.

Automobile, Accident, or Liability Coverage – This Plan shall not furnish benefits that duplicate the benefits to which a Member is entitled under any other automobile, accident, or liability coverage. Member is responsible for taking whatever action is necessary to obtain the benefits of such coverage when it is available and shall notify PBHI of such coverage when available. If benefits are furnished by this Plan in duplication of the benefits available to Member under other automobile, accident or liability coverage, this Plan may seek reimbursement to the extent of the reasonable value of the benefits furnished by this Plan from the insurance carrier, provider and Member.

Should the cost of Behavioral Health Services exceed the coverage of any applicable other coverage pursuant to this Section, this Plan shall furnish benefits over and above such coverage.

Coordination of Benefits (COB) – This Plan contains a COB provision that prevents duplication of payments. When a Member is eligible for benefits under any other valid coverage, the combined benefit payments from all coverage cannot exceed 100 percent of the Plan's covered expenses. All of the benefits furnished under this Plan are subject to this provision. When this Plan is secondary, all provisions (such as

using a Participating Provider, and/or obtaining prior approval) must be followed. Failure to do so may result in no benefits or reduced benefits from PBHI.

The following rules determine which coverage pays first:

No COB Provision

a) If the other valid coverage does not include a COB provision, that coverage pays first and this Plan pays secondary benefits.

Subscriber/Dependent

b) The benefits of a plan that covers the Member as a Subscriber shall be determined before the benefits of a plan, which covers such Member as a Dependent.

Dependent Child

c) Except as stated in subparagraph d) below, the benefits of the Plan of the parent whose month and day of birth occurs earlier in a Calendar Year, shall be determined before the benefits of a plan of the parent whose month and day of birth occurs later in a calendar year. If the other coverage does not follow this birthday rules, then the father's coverage pays first.

Custodial/Non-custodial Parent

d) In the case of a Member for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

e) In the case of a Member for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. In addition, the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Court Decree Obligations

f) In the case of a Member for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding rules d) and 3), the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

Active/Inactive Employee

g) The benefits of a plan covering the person as a laid-off or retired employee, or as a dependent of such person, shall be determined after the benefits of any other plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person; and if either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then the next rule applies.

Longer/Shorter Length of Coverage

h) When rules a) through g) do not establish an order of benefit determination, the benefits of a plan which has covered the Member for the longer period of time shall be determined before the benefits of a plan which has covered such Member the shorter period of time.

When this provision operates to reduce the total amount of benefits otherwise payable to a person covered under this Plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

Right to Receive and Release Necessary Information – For the purpose of determining the applicability of and implementing of the terms of this provision of this Plan or any provision of similar purpose of any other Plan, this Plan may release to or

obtain from any insurance company or other organization or person any information, with respect to any person, which this Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement this provision.

Facility of Payment – Whenever payment which should have been made under this Plan in accordance with this provision have been made under any other Plans, this Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent such payments, this Plan shall be fully discharged for liability under this Plan.

Right of Recovery – Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, this Plan shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as this Plan shall determine: any persons to or for or with respect to whom such payment were made, any insurers, service plan or any other organizations.

Covered Services

Behavioral Health Services are covered only when they are:

- **Incurred while the Member is eligible for coverage under this Behavioral Health Plan;**
- **Pre-authorized by PBHI as Medically Necessary; and**
- **Rendered by a PBHI Participating Provider, except in the case of an Emergency.**

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

I. **Mental Health Service**s (including services for the diagnosis and treatment of SMI and SED conditions:

   A. *Inpatient*

      1. Inpatient Mental Health Services provided at an Inpatient Treatment Center or Day Treatment Center are covered when Medically Necessary, pre-authorized by PBHI, and provided at a Participating Facility.
      2. Inpatient Physician Care – Medically Necessary Mental Health Services provided by a Participating Practitioner while the Member is hospitalized as an inpatient at an Inpatient Treatment Center or is receiving services at a Participating Day Treatment Center and which have been pre-authorized by PBHI.

   B. *Outpatient*

      1. Outpatient Physician Care – Medically Necessary Mental Health Services provided by a Participating Practitioner and pre-authorized by PBHI. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.

II. **Chemical Dependency Services**

   A. *Inpatient*

      1. Inpatient Chemical Dependency Services, including Medical Detoxification provided at an Inpatient Treatment Center – Medically Necessary Chemical Dependency Services, which have been pre-authorized by PBHI and are provided by a Participating Practitioner while the Member is confined in at a Participating Inpatient Treatment Center, or at a Participating Residential Treatment Center.
      2. Inpatient Physician Care – Medically Necessary Chemical Dependency Services, 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 pre-authorized by PBHI.

3. Chemical Dependency Services Rendered at a Residential Treatment Center – Medically Necessary Chemical Dependency Services provided by a Participating Practitioner, provided to a Member during a confinement at a Residential Treatment Center are covered, if provided or prescribed by a Participating Practitioner and pre-authorized by PBHI.

B. *Outpatient*

1 Outpatient Physician Care – Medically Necessary Chemical Dependency Services provided by a Participating Practitioner and pre-authorized by PBHI. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.

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 system 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 for a non-Emergency is covered only when specifically authorized by PBHI.

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 Chemical Dependency when pre-authorized by PBHI.

3. *Inpatient Prescription Drugs* – Inpatient prescription drugs are covered only when prescribed by a PBHI Participating Practitioner for treatment of a Mental Disorder or Chemical Dependency while the Member is confined to an Inpatient Treatment Center or, in the case of treatment of Chemical Dependency a Residential Treatment Center.

4. *Injectable Psychotropic Medications* – Injectable psychotropic medications are covered if prescribed by a PBHI Participating Practitioner for treatment of a Mental Disorder when pre-authorized by PBHI.

5. *Psychological Testing* – Medically Necessary psychological testing is covered when pre-authorized by PBHI and provided by a Participating Practitioner who has the appropriate training and experience to administer such tests.

6. Counseling in preparation for or associated with a sex change operation.

Cost Control Reduction

The Percentage Payable is reduced by 30 percent when a Member leaves any Chemical Dependency Treatment Program prior to the authorization by the Case Manager of the discharge or transfer plan.

Exclusions

Unless described as a Covered Service in an attached supplement, all services and benefits described below are excluded from coverage under this Behavioral Health Plan. Any supplement must be an attachment to this *Summary Plan Description*.

1. Any confinement, treatment, service or supply not authorized by PBHI, except in the event of an Emergency or an Urgently Needed Service.
2. All services not specifically included in the PBHI *Schedule of Behavioral Health Benefits*, included with this *Summary Plan Description*.
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 PBHI.
5. Services or treatment provided to you which duplicate the benefits to which you are entitled under any applicable Workers' Compensation law

are not covered, as described in the Section of this *Summary Plan Description* titled 'Workers' Compensation Insurance'.

6. Any services that are provided by 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.
7. Speech therapy, physical therapy and occupational therapy services provided in connection with the treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay, including delayed language development, are not covered.
8. Treatments which do not meet national standards for mental health professional practice.
9. Routine, custodial, and convalescent care, long term therapy and/or rehabilitation. (Individuals should be referred to appropriate community resources such as school district or regional center for such services).
10. Services provided by non-licensed providers are not covered.
11. Pastoral or spiritual counseling.
12. Dance, poetry, music or art therapy except as part of a Behavioral Health Treatment Program.
13. School counseling and support services, home based behavioral management, household management training, peer support services, recreation, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, wraparound services, emergency aid to household items and expenses, and services to improve economic stability and interpretation services.
14. Genetic counseling services.
15. Community Care Facilities that provide 24-hour non-medical residential care.
16. Weight control programs and treatment for addictions to or dependency on tobacco, nicotine; treatment for caffeine dependency or dependency on any food substance.
17. Counseling for adoption, custody, family planning or pregnancy in the absence of a DSM-IV diagnosis.
18. Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence.
19. Personal or comfort items, and non-Medically Necessary private room and/or private duty nursing during inpatient hospitalization are not covered.
20. With the exception of injectible psychotropic medication, all non-prescription 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. (Non-prescription and prescription drugs prescribed by a PBHI Participating Practitioner while the Member is confined at an Inpatient Treatment Center and non-prescription 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.)
21. Surgery or acupuncture.
22. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not Medically Necessary.
23. Neurological services and tests, including, but not limited to, EEGs, Pet scans, beam scans, MRI's, skull x-rays and lumbar punctures.
24. Treatment sessions by telephone or computer Internet services.
25. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations, or career counseling.
26. Educational services to treat developmental disorders, including autism, developmental delays or learning disabilities are not covered. A learning disability is a condition where there is a meaningful difference between a child's current academic level

of function and the level that would be expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading and psychological and visual integration training as defined by the American Academy of Pediatrics Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review.

27. Treatment of problems that are not Mental Disorders are not covered, except for diagnostic evaluation.

28. 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 *Summary Plan Description* 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 PBHI Medical Director or a designee. For the purpose of this *Summary Plan Description*, 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 PBHI in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this 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 Health Care Policy and Research (AHCPR);
- PBHI Technology Assessment Committee Guidelines.

A Member with a Life-Threatening or Seriously Debilitating condition may be entitled to an expedited external, independent review of PBHI's coverage determination regarding Experimental or Investigational therapies as described in the Section of this *Summary Plan Description* captioned "Expedited Review Process".

29. Expenses incurred due to liable third parties are not covered, as described in the Section of this Evidence of Coverage title "Third Party Liability".
30. Mental Health Services rendered at a Residential Treatment Center or other facilities or institutions that are not Inpatient Treatment Centers.
31. Treatment for conditions often described as compulsive gambling.
32. Services which are provided by a non-licensed Practitioner or a non-licensed Facility.
33. Methadone maintenance or treatment.
34. Durable medical goods.
35. Nutritional counseling.
36. Catastrophic illness diagnosis.
37. Physical needs from suicide.
38. Medical Detoxification.
39. Services furnished by a relative.

Miscellaneous Provisions

Plan Administration

By authority of the Regents, University of California Human Resources and Benefits, located in Oakland, California administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by the Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Insurance Contracts/Administrative Services Agreement. What is written in this document does not constitute a guarantee of plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

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

Sponsorship and Administration of the Plan

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

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

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

Claims under the Plan are processed by PacifiCare Behavioral Health, Inc. at the following address and phone number:

PacifiCare Behavioral Health, Inc.
Claims Department
P.O. Box 31053
Laguna Hills, CA 92654
(800) 817-8811

Group Contract Number

The Group Contract Number for this Plan is: 10000206

Type of Plan

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

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, Plan costs and what portion of the Plan costs the University will pay. The portion of the Plan costs that the University pays is determined by UC and may change or stop altogether, and may be affected by the State of California's annual budget appropriation.

Financial Arrangements

The coverage described in your booklet is provided by the University of California on a self-funded basis under the University of California Employee Benefit Plan. Administrative Services are provided by PacifiCare Behavioral Health, Inc. under an Administrative Services Agreement between the Regents of the University of California and PacifiCare Behavioral Health, Inc.

The cost of the premiums is currently shared between you and the University of California.

The following applies to the benefits under the Plan. Any dollar amounts remaining in a participant's account will be forfeited to the Plan if the funds are not claimed within three years from the date of issue. If the participant has not accepted the distribution, corresponded in writing regarding the distribution or indicated an interest in the distribution within three years after it became distributable, the participant may make a claim to the Plan for reimbursement of the forfeited benefit.

Agent for Serving of Legal Process

Legal process may be served on the Plan Administrator or on the claims processor at the applicable address listed above.

Your Rights under the Plan

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

- Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Group Contracts, at a time and location mutually convenient to the participant and the Plan Administrator.
- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan

To file a claim or to appeal a denied claim, refer to page 10 of this document.

Nondiscrimination Statement

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

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Amendments

This *Summary Plan Description* may be amended or terminated at any time in the Plan Sponsor's discretion. Members will receive notice of any amendment of this Plan. No one has the authority to make any oral modification to this *Summary Plan Description*.

Notice

All notices, whether to the Plan from Members or to Members from PBHI, must be written and sent through first class mail.

Definitions

PBHI 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 terms used in your *Summary Plan Description*, as well as the *Schedule of Behavioral Health Benefits*. Please refer to the *Schedules of Behavioral Health Benefits* to determine which of the definitions below apply to your benefit plan.

Administrative Service Agreement. The Agreement for the provision of Behavioral Health Services between the Plan Sponsor and PBHI.

Assessment Process. The process by which the PBHI Clinician gathers information to determine Medical Necessity. The Member is asked a series of questions about the current life circumstances that are contribution to his/her lack of psychological well-being. The interview includes specific questions about areas of emotional duress and to what degree there is an impairment of functioning at the Member's work, leisure and daily activities. The information is quantified into a numerical basis to facilitate tracking the quality of treatment and the effectiveness of treatment.

Behavioral Health Services. Services for the Medically Necessary diagnosis and treatment of Mental Disorders and Chemical Dependency, which are provided to Members pursuant to the terms and conditions of the PBHI Behavioral Health Plan.

Behavioral Health Plan. The PBHI Behavioral Health Plan that includes coverage for the Medically Necessary diagnosis and treatment of Mental Disorders and Chemical Dependency, as described in the Administrative Services, this *Summary Plan Description*, and the *Schedule of Behavioral Health Benefits*.

Behavioral Health Treatment Plan. A written clinical presentation of the PBHI Participating Provider's diagnostic impressions and therapeutic intervention plans. The Behavioral Health Treatment Plan is submitted routinely to a PBHI Clinician 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 Chemical Dependency and/or Mental Disorders.

Calendar Year. The period of time from 12:00 A.M. on January 1 through 11:59 P.M. on December 31. Each succeeding like period will be considered a new Calendar Year.

Calendar Year Deductible. The amount of Covered Expense a Member is responsible to pay per Calendar Year before benefits become payable under this Employee Behavioral Health Benefits Plan.

Chemical Dependency. An addictive relationship between a Member and any drug, alcohol or chemical substance that can be documented according to the criteria in the DSM-IV-TR. Chemical Dependency does not include addiction to or dependency on (1) tobacco in any form or (2) food substances in any form.

Chemical Dependency Inpatient Treatment Program. A structured medical and behavioral inpatient program aimed at the treatment and alleviation of Chemical Dependency.

Chemical Dependency Services. Medically Necessary services provided for the treatment of Chemical Dependency, which have been pre-authorized by PBHI.

Chemical Detoxification. Routine treatment and stabilization for symptoms resulting from withdrawal from chemical substance, including drugs or alcohol, which does not require intensive nursing, monitoring or procedures such as intravenous fluids. Where such services are a covered benefit, Members must:

- Obtain medical clearance from Primary Care Physician prior to receiving Chemical Detoxification form PBHI, and
- Receive Chemical Detoxification services from a Participating Provider.

Contracted Rate. The rate, or percentage thereof, that the Participating Provider agrees to accept from Plan Sponsor as payment in full for covered services, excluding any applicable Copayments by the Member.

Copayments. Costs payable by the Member at the time Covered Services are received. Copayments may be a specific dollar amount or a percentage of Covered

Charges as specified in this *Summary Plan Description* and are shown on the PBHI *Schedule of Behavioral Health Benefits*.

Covered Services. Medically Necessary Behavioral Health Services provided pursuant to the Administrative Agreement, this *Summary Plan Description* and *Schedule of Behavioral Health Benefits* for Emergencies or those Behavioral Health Services which have been pre-authorized by PBHI.

Covered Expenses. An expense that:

- is incurred for a Behavioral Health Service provided to a Member while that person is covered under this Plan;
- does not exceed the Maximum Benefit that may apply to the expense; and
- does not exceed the applicable negotiated fees of a Participating Provider.

Customer Service Department. The department designated by PBHI to whom oral or written Member issues may be addressed. The Customer Service Department may be contacted by telephone at 1-800-817-8811 or in writing at:

PacifiCare Behavioral Health, Inc.
Post Office Box 55307
Sherman Oaks, California 91413-0307

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 PBHI Participating Practitioner and which is also licensed, certified, or approved to provide such services by the appropriate state agency.

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

Diagnostic and Statistical Manual (or DSM-IV-TR). The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, which is published by the American Psychiatric Association and which contains the criteria for diagnosis of Chemical Dependency and Mental Disorders.

Emergency or Emergency Services. A behavioral health condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the Prudent Layperson would expect the absence of immediate Behavioral Health Services 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.

If you or your Dependent are temporarily outside of New Mexico, experience a situation which requires Behavioral Health Services, and a delay in treatment from a PBHI Participating Provider in New Mexico would result in a serious deterioration to your health, the situation will be considered an Emergency.

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 Treatment. An unproven procedure or treatment regimen that does not meet the generally accepted standards of usual professional medical practice in the general medical community.

Facility. A entity which is duly licensed by the state in which it operates to provide inpatient, day treatment, partial hospitalization or outpatient care for the diagnosis and/or treatment of Chemical dependency of Mental Disorders.

Grievance Procedure. The procedure for reviewing complaints of Members.

Group Therapy. Goal-oriented Behavioral Health Services provided in a group setting (usually about 6 to 12 participants) by a PBHI Participating Practitioner. Group Therapy can be made available to the Member

in lieu of individual outpatient therapy when appropriate. Please refer to you *Schedule of Behavioral Health Benefits* for further information.

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 PBHI Participating Practitioner, and which also:

- provides 24-hour nursing and medical supervision;
- has established a written referral relationship with a local hospital for patients beyond its scope of treatment capability; and
- is licensed, certified, or approved as such by the appropriate state agency.

Maximum Benefit. The lifetime or annual maximum amount shown in the PBHI *Schedule of Behavioral Health Benefits* which PBHI will pay for any authorized Behavioral Health Services provided to Members by PBHI Participating Providers.

Medical Detoxification. In most cases of alcohol, drug or other substance abuse or toxicity, outpatient treatment is appropriate unless another medical condition requires treatment at an Inpatient Treatment Center.

Medical Expenses. Any costs related to physical illness or injury.

Medically Necessary (or Medical Necessity). Refers to Behavioral Health Services or supplies for treatment of a Mental Disorder or Chemical Dependency that are determined by PBHI's Medical Director (or designee) to be:

- Rendered for the treatment and diagnosis of a Mental Disorder and Chemical Dependency, as defined by the DSM-IV-TR and limited to the impairment of a Member's mental, emotional or behavioral functioning,
- Appropriate for the severity of symptoms, consistent with diagnosis, and otherwise in accordance with generally accepted medical practice and professionally recognized standards, which shall include the consideration of scientific evidence;
- Not furnished primarily for the convenience of the Member, the attending physician, or other provider of service; and
- Furnished at the most cost-effective manner, which may be provided safely and effectively to the Member.

"Scientific evidence", as referenced above, shall include peer reviewed medical literature, publications, reports and other authoritative medical sources.

Medicare. The Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act as amended.

Medicare Retiree. A Member who is:

- eligible for Medicare Part A and Part B;
- no longer eligible for benefits as an active employee or a Dependent of an active employee;
- properly enrolled in this Behavioral Health Plan; and
- eligible for benefits under this Behavioral Health Plan pursuant to the requirements set forth in the University of California Eligibility, Enrollment, Termination, and Plan Administration Provisions found in this Summary Plan Description.

Member. The Subscriber or any Dependent, as described in the University of California Eligibility, Enrollment, Termination and Plan Administration Provisions found in this Summary Plan Description.

Mental Disorder. A mental or nervous condition diagnosed by a licensed Participating Practitioner according to the criteria in the DSM-IV-TR resulting in the impairment of a Member's mental, emotional, or behavioral functioning. Mental Disorders include the Severe Mental Illness of a person of any age and the Serious Emotional Disturbances of a child.

Mental Health Services. Medically Necessary Behavioral Health Services for the treatment of Mental Disorders.

Open Enrollment Periods. The periods during which all eligible employees and their eligible Dependents may enroll in this Behavioral Health Plan.

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

PacifiCare Behavioral Health, Inc. ("PBHI"). The Administrator that the Plan Sponsor has contracted with for administrative services, including but not limited to premium billing and collection, claims payment, case management, pre-authorization and provider access.

Participating Facility. A health care or residential facility which is duly licensed by the state in which it operates to provide inpatient, residential, day treatment, partial hospitalization, or outpatient care for the diagnosis and/or treatment of Covered Behavioral Health Services and which has entered into a written agreement with PBHI.

Participating 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 in the state in which he or she operates and who has entered into a written agreement with PBHI to provide Covered Behavioral Health Services to Members.

Participating Providers. Participating Practitioners, Participating Preferred Group Practices and Participating Facilities, collectively, each of which has entered into a written agreement with PBHI to provide Behavioral Health Services to Members.

Participating Preferred Group Practice. A provider group or independent practice association duly organized and licensed in the state in which it operates to provide Behavioral Health Services through agreements with individual behavioral health care providers, each of whom is qualified and appropriately licensed to practice his or her profession in New Mexico.

PBHI Clinician. A person licensed as a psychiatrist, psychologist, clinical social worker, marriage, family and child therapist, nurse, or other licensed health care professional with appropriate training and experience in Behavioral Health Services, who is employed or under contract with PBHI to perform case management services.

Plan Sponsor. The University of California.

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 the state in which he or she operates.

Pre-Authorized Services. Those Behavioral Health benefits described in the *Schedule of Behavioral Health Benefits*, and which are Medically Necessary and authorized by a PBHI Clinician.

Prevailing Rate. The usual, reasonable and customary rates for a particular Behavioral Health Services in the service area.

Quality Review. The PBHI procedure of reviewing complaints related to the quality or appropriateness of Behavioral Health Services provided or arranged by PBHI or a Participating Practitioner.

Residential Treatment Center. A residential facility that provides services in connection with the diagnosis and treatment of behavioral health conditions and which is licensed, certified, or approved as such by the appropriate state agency.

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

Subscriber. The person who enrolls in the PBHI Behavioral Health Plan and who meets all the applicable eligibility requirements of the Group and PBHI, and for whom Plan Premiums have been received by PBHI.

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-IV-TR, in order to qualify for coverage under this PBHI Plan. Determination of disability shall be based upon a comprehensive psychiatric examination by a

Participating PBHI Provider.

Treatment Plan. A structured course of treatment authorized by a PBHI Clinician 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 manifesting itself by acute symptoms of sufficient severity, such that treatment cannot be delayed.

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

Notes

Notes

3120 Lake Center Drive
Santa Ana, CA 92704-6917

Customer Service:
800-817-8811
888-877-5378 (TDHI)

Visit our Web site @ www.pbhi.com

© 2005 by PacifiCare Behavioral Health, Inc.
PBHB1478-01/05

PacifiCare®
Behavioral Health