

## **DEFINITIONS**

### **Behavioral Health Services, BHSA**

Services and supplies which are:

- Covered Services for BHSA Treatment.
- Provided while the Covered Person is covered under the plan.
- Provided by one of the following providers:
  - Physician
  - Psychologist
  - Licensed Counselor
  - Provider
  - Hospital
  - Treatment Center
  - Social Worker
- Behavioral Health Services include but are not limited to the following:
  - Applied Behavior Analysis Therapy (ABA)
  - Assessment
  - Diagnosis
  - Treatment Planning
  - Medication Management
  - Individual, family and group psychotherapy
  - Psychological testing
  - Nicotine use and tobacco dependency

### **Calendar Year**

A period of one year beginning January 1, 2019.

### **Covered Expenses**

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

## **Covered Person**

You and your spouse or domestic partner and / or dependent child(ren) who are covered under this Plan.

## **Covered Services**

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

## **Emergency Care**

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

Screening, examination and evaluation by a Physician, or other Provider to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency, within the capability of the facility.

## **Employee**

A person on the payroll and regularly employed on a full-time basis of not less than 30 hours per week.

## **Hospital**

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

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

## **Licensed Counselor**

A person who specializes in mental disorders' treatment and holds a license as a Licensed Professional Counselor (L.P.C.) or a Licensed Clinical Social Worker (L.C.S.W.) by the appropriate authority.

## **BHSA Treatment**

BHSA Treatment is behavioral health and / or substance abuse treatment for the following:

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

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

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

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

Prescription Drugs are not considered BHSA Treatment.

## **MNRP**

The behavioral health benefits are set-up as a Percentage of Medicare (MNRP)

Eligible Physician Claims: Expenses are determined based on 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS).

Facility Claims: Eligible Expenses are determined based on % of billed charges equivalent (or better) to 140% of Medicare.

## **Network Provider**

A provider that participates in the UBH network.

## **Non-Network Provider**

A provider that does not participate in the UBH network.

## **Physician**

A legally qualified:

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

## **Plan Sponsor**

The employee welfare benefit plan established by Franklin County Cooperative Health Improvement Program that provides the benefits described in this Summary Plan Description.

## **Provider**

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

## **Psychologist**

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

- A person licensed or certified as a psychologist; or,
- A member or fellow of the American Psychological Association, if there is not government licensure or authorization required.

As to charges for services rendered by or on behalf of a Non-Network Provider, an amount measured and determined by UBH by comparing the actual charge for the service or supply with the prevailing charges made for it. The prevailing charge is determined by taking all the following into account:

- The complexity of the service;
- The range of services provided; and,
- The prevailing charge level in the geographic area where the provider is located.

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

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

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

## **Treatment Center**

A facility that provides a program of effective BHTA treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and the Plan Sponsor.
- It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:

- Room and board (if this Plan provides inpatient benefits at a Treatment Center);
- Evaluation and diagnosis;
- Counseling; and
- Referral and orientation to specialized community resources.

A Treatment Center that qualifies as a Hospital is covered as a Hospital and not as a Treatment Center. Definitions for the various intermediate levels of facility-based care are as follows:

**Intensive Outpatient Program (IOP):** A structured outpatient program that may be freestanding or hospital-based and that provides services for at least 3 hours per day, 2 or more days per week. IOPs encompass half-day partial hospital programs. Intensive Outpatient Programs are used as a step up from routine outpatient services, or as a step down from acute inpatient, residential care or a partial hospital program. Intensive Outpatient Programs can be used to treat mental health conditions or Substance-Use Disorders, or can specialize in the treatment of co-occurring mental health conditions and Substance-Use Disorders.

**Outpatient Care:** Treatment provided in an ambulatory setting for the purpose of assessing and treating a behavioral health condition.

**Partial Hospital Program (PHP):** A structured ambulatory program that may be freestanding or hospital-based and that provides services for at least 5 hours per day and at least 4 days per week. Partial hospital programs are used as a step up from routine or intensive outpatient services, or as a step down from acute inpatient or residential care. Partial hospital programs can be used to treat mental health conditions or Substance-Use Disorders, or can specialize in the treatment of co-occurring mental health conditions and Substance-Use Disorders. Also known as a Day Treatment Program.

**Residential Detoxification:** Residential detoxification is comprised of services that are provided in a residential setting other than an acute care hospital for the purpose of completing a medically safe withdrawal from substances. Residential detoxification is typically indicated when withdrawal is severe enough to warrant 24-hour care, but on-site access to medical personnel is not essential.

**Residential Rehabilitation:** Acute overnight services that are typically provided in a freestanding Residential Treatment Center for the care of a Substance-Use Disorder. A residential rehabilitation program is appropriate when a covered person lacks the motivation or social support system to remain abstinent, but does not require the structure and the intensity of services provided in a hospital.

**Residential Treatment Center (RTC):** Facility-based or freestanding program that provides overnight mental health services for patients who do not require acute care.

**23-Hour Observation:** A facility-based program that provides a medically safe environment for up to 23 hours during which rapid and time-limited assessment, stabilization and referral services are provided in order to assist covered persons in coping with a crisis and gaining access to the next appropriate level of care.

**Urgent Care:** A service that, if subject to non-urgent or routine procedures, could seriously jeopardize the covered person's life or health, or could jeopardize the covered person's ability to regain maximum function, or in the opinion of the treating clinician, the care requested is urgent or if not provided would cause the enrollee severe pain. Whether a request for services meets the definition is to be determined

based on the prudent layperson standard. A request from a clinician or physician with knowledge of the covered person's condition will be considered an urgent request if the clinician or physician determines it to be urgent. All covered persons needing urgent care will be offered an appointment within 48 hours.

**Wraparound Service:** A treatment-oriented, goal-directed service provided to a covered person (and/or a covered person's family/social support system) who is recovering from a severe behavioral health condition. Wraparound services are intended to reduce the risk that a covered person's condition will worsen or recur, and to increase the likelihood that the covered person will be able to maintain a reasonable standard of living in his/her community.

### **Utilization Review**

A review and determination of whether services and supplies are Covered Services.

## **Behavioral Health Benefits**

### **Who is Administering Your Behavioral Health Benefits?**

United Behavioral Health (Optum) is administering your mental health and substance abuse benefits.

### **What Does this Plan Pay for?**

Your benefit pays for Covered Expenses incurred for Behavioral Health Services that you or eligible family members might use from either a Network or Non-Network Provider. A Network Provider refers to a provider who is part of the UBH network.

**Effective January 1, 2018**

Level of Care	EAP Benefit	Behavioral Health - In Network	Behavioral Health – Non-Network
*Deductible	\$0	N/A	\$800 Individual/\$2,000 Family Combined with Medical
*Maximum Out-of-Pocket		\$2000 Individual/\$5,000 Family Combined with Medical	\$4,000 Individual/\$10,000 Family Combined with Medical
*Outpatient	8 visits at 100%	Office visit Co-payment Visits 1-30: No Copay  Visits 31+: \$20	Plan pays 140% of published MGRP After deductible
*Inpatient		Plan pays 100% coverage	Plan pays 80% of coverage after deductible. Pre-authorization is required for Non-Network services or benefit reduces to 50% of eligible expenses.
*Intermediate Care		Days are limited by medical necessity; covered at 100%	Plan pays 80% of coverage after deductible
<p><b>*All Network &amp; Non-Network Services Require Pre-Authorization</b>  <b>*Participation in the annual ThriveOn Wellness Program may reduce your out of pocket expenses.</b></p>			

If you require assistance beyond what is provided under the EAP, you will be transitioned to your Behavioral Health Plan benefits. In order to receive the maximum benefit, you must seek services from an in-network provider.

**Negotiated Rates from Non-Network Providers Paid as Network Benefits**

If specific Covered Services are not available from a Network Provider, you may be eligible for Network Benefits when Covered Services are received from Non-Network Providers. In this situation, UBH will work with you to coordinate care through a Non-Network Provider.

When you receive Covered Services through a Network Physician, we will pay Network Benefits for those Covered Services, even if one or more of those Covered Services is received from a Non-Network Provider.

**Non-Network Benefits**

Non-Network Benefits are paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Services that are provided by Non-Network Physicians or Non-Network Providers. Non-Network Benefits are also payable for Covered Services that are provided at Non-Network facilities.

**Your Responsibility for Pre-Authorization**

In order to receive the maximum benefit, you should utilize a UBH Network Provider. You must request authorization from UBH before receiving Covered Services from Network & Non-Network Providers. If you fail to notify UBH; Benefits will be reduced. Prior notification does not mean Benefits are

payable in all cases. Coverage depends on the Covered Mental Health/Substance Abuse Services that are actually given and your eligibility status, and any benefit limitations.

## **Emergency Services**

The Plan provides Benefits for Emergency Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Services, even if the services are provided by a Non-Network Provider.

- If you are confined in a Non-Network Hospital after you receive Emergency Services, UBH must be notified within one business day or on the same day of admission if reasonably possible. UBH may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the Non-Network Hospital after the date UBH decides a transfer is medically appropriate, Non-Network Benefits are not available if the continued stay is determined to be a Covered Service.
- If you are admitted as an inpatient to a Network Hospital within 24 hours of receiving treatment for the same condition as an Emergency Service, you will not have to pay the Co-payment for Emergency Services. The benefit for an Inpatient Stay in a Network Hospital will apply.

**Note:** The Co-payment for Emergency Services WILL NOT BE WAIVED if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the hospital.

## **Authorization Requirements**

Prior authorization is required before you receive Covered Services. To notify UBH, call the telephone number on the back of your medical ID card for Customer Service.

We urge you to confirm with UBH that the services you plan to receive are Covered Services. In some instances, certain procedures may not meet the definition of a Covered Service and are therefore excluded. In other instances, the same procedure may meet the definition of Covered Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

To receive the highest level of benefits, call UBH before you receive inpatient or outpatient mental health and/or substance abuse services.

- In the most recent edition of the current procedural terminology and / or Diagnostic and Statistical Manual (DSM) Code;
- As reported by recognized professionals or publications.

Behavioral Health Services are services and supplies which are:

- Covered Services, for BHSA Treatment
- Provided while the Covered Person is covered under this Plan
- Provided by one of the following providers:



- Physician
- Psychologist
- Licensed Counselor
- Provider
- Hospital
- Treatment Center
- Social Worker

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

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

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

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

## **HOW TO USE YOUR BENEFITS**

When you are ready to access your benefits, please call UBH's toll-free number 1-800-354-3950, which is available 24 hours-a-day, seven days-a-week. A UBH clinician will answer your call and begin the Utilization Review process. Through Utilization Review, UBH assesses your issue or problem, then makes sure that you receive the level of care you need to address your symptom(s) and its level of acuity. To assess your symptom(s), UBH uses a set of industry-approved and clinically based guidelines. After UBH assesses your personal situation, you will be referred to a Network Provider who is experienced in addressing your specific issues.

The care you receive through your Behavioral Health Benefit is confidential. UBH shall not disclose confidential information to anyone without your consent, except where required by Federal and State laws.

- Contact UBH before you visit either a Network or Non-Network Provider. If you do not get a UBH referral beforehand, you will not receive the maximum benefit.

### **What if You are Unsatisfied with Your Current Network Provider?**

Call UBH and ask for a referral to another Network Provider. You will receive one Network Provider referral at a time, but you can change more than once.

## **Emergency Care**

If you are facing a crisis and must go to an emergency room, you do not need a referral from UBH. However, you (or your representative or your Physician) must call UBH within 24 hours after the Emergency Care is given. If this is not reasonably possible, the call must be made as soon as reasonable possible.

Remember, once Emergency Care is ended, call UBH to get a referral to receive any additional services covered at the Network level. Without a required referral, benefits for any additional services will be paid at the Non-Network level.

## **Copayments and Deductibles**

You must satisfy certain copayments and / or deductibles before behavioral health benefits are payable.

A copayment is the amount you must pay to your Network Provider when services are provided. Behavioral Health Services that require a copayment do not require a deductible.

A deductible is the amount you must pay before behavioral health benefits are payable. After you meet the deductible, your Covered Expenses are payable at the percentage shown in Schedule of Benefits (see p. 6).

See the Schedule of Benefits on p. 7 for each copayment / deductible amount. You must make a copayment or pay a deductible each time you use your benefits, when applicable. For example, one copayment on a Network Provider visit does not satisfy the copayments for subsequent visits.

## **Office Visit Copayment**

The office visit copayment is made for all services and supplies given with each office visit to a Network Provider.

## **Non-Network Inpatient Deductible**

Each time you stay in a Non-Network Hospital, Treatment Center, or facility specializing in behavioral health treatment for 24-hour care, you must pay the non-network inpatient deductible.

## **Non-Network Outpatient Deductible**

The non-network outpatient deductible applies for each visit to a Non-Network Provider, or when you receive a service from a Non-Network Provider.

## **MAXIMUM BENEFIT**

You will not be penalized if we switch to another Plan while a covered person is in treatment. (You will have maximum benefits the day before the effective date of this Plan.) You have **90** days from the day the new benefits begin to finish treatment with your current Provider, transfer to one of UBH's Network Providers, or pay at the Non-Network level.

## NOT COVERED-EXCLUSIONS

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

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

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM).
- Prescription drugs or over the counter drugs and treatments. (Refer to your medical plan to determine whether prescription drugs are a covered benefit.)
- UBH may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.
- Services or supplies for BHSA Treatment that, in the reasonable judgment of UBH are any of the following:
  - Are not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
  - Are not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
  - Are not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;
  - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or
  - Are not consistent with UBH's Level of Care Guidelines or best practice as modified from time to time.
- Treatment of services, except for the initial diagnoses, for a primary diagnoses of Mental Retardation (317,318,319), Learning, Motor Skills, and Communication Disorders (315), Pervasive Developmental Disorder (299), Conduct Disorder (312), Dementia (290, 294), Sexual, Paraphilia, and Gender Identity Disorders (302), and Personality Disorders (301), as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by UBH.
- Unproven, Investigational or Experimental Services: Services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a Covered Service if the service, treatment, or device is considered to be unproven, investigational, or experimental.

- Custodial Care, except for acute stabilization or a protected, controlled environment, and then returned back to your baseline level of individual functioning. Care is determined to be custodial when:
  - It is providing services necessary to assure competent functioning in activities of daily living; or
  - Nervous or mental retardation conditions that primarily involve custodial care including mental retardation, organic brain syndrome, non-psychotic brain syndrome, and neuroses that are of a functional-type origin.
- Neuropsychological testing when used for the diagnosis of attention deficit disorder.
- Examinations or treatment, unless it otherwise qualifies as Behavioral Health Services, when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
  - Ordered by a court except as required by law;
  - Conducted for purposes of medical research; or
  - Required to obtain or maintain a license of any type.
- Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of National Institutes of Health.
- Nutritional Counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan. (Refer to your medical plan for additional nutritional counseling resources and covered benefits.)
- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment rendered by unlicensed providers, including pastoral counselors (except as required by law), or which are outside the scope of the providers' licensure.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
- Light boxes and other equipment including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while confined in a facility.
- Surgical procedures including but not limited to sex transformation operations. (Refer to your medical plan to determine covered services.)
- Smoking cessation related services and supplies. (Refer to your pharmacy plan to determine covered services.)
- Travel or transportation expenses unless UBH has requested and arranged for you to be transferred by ambulance from one facility to another.

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with the same legal residence as you.
- Behavioral Health Services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- Charges in excess of any specified Plan limitations.
- Any charges for missed appointments.
- Any charges for record processing except as required by law.
- Services Provided Under Another Plan. Service or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes but is not limited to coverage required by workers' compensation, no-fault auto, or similar legislation. If coverage under workers' compensation or a similar law is optional for you because you could elect it or could have it elected for you, benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected.
- Behavioral Health Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country when you are legally entitled to other coverage.
- Treatment or services received prior to you being eligible for coverage under the Plan or after the date your coverage under the Plan ends.

## **NETWORK PROVIDER CHARGES NOT COVERED**

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

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

Covered persons may pay the Network Provider for any charges which are not Covered Services. In this case, your Network Provider may charge you directly with your written authorization. You will be asked to sign a patient financial responsibility form. This means you agree to pay for the services that are found not to be Covered Services. Remember, these charges are not Covered Expenses and will not be paid under this Plan.

## **CLAIMS INFORMATION**

### **Why Would You Want to File a Claim?**

You do not need to file claims for Network Provider services. Network Providers will automatically file claims with UBH. However, you may need to file a claim for Non-Network Provider services. Instructions for filing a claim are outlined below:

### **How to File a Claim**

- Obtain a claim form from a Non-Network Provider, the Plan Administrator, or United Behavioral Health. Non-network claims can also be filed electronically online at [www.liveandworkwell.com](http://www.liveandworkwell.com) after creating your personal profile. The initial access code for Franklin County Cooperative members is: **EAP**.
- Complete the Employee portion of the form.
- Have the Provider complete the provider portion of the form.
- Send the form and bills to the address shown on the form.
- Attach a check for the non-network deductible portion.

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

- Your name and member identification or social security number.
- Franklin County Cooperative Health Improvement Program.
- The patient's (yours or the eligible family member's) name.
- The diagnosis.
- The date the service(s) or supply(ies) were provided.
- The specific service(s) or supply(ies) provided.

If you ask for a claim form but do not receive it within 15 days, you can file a claim without the form by sending the bills with a letter, including all of the information listed above to **UBH, Claims Department, P.O. Box 30755 Salt Lake City, UT. 84130-0755**

### **How and When Claims are Paid**

You will be paid for all expenses when UBH receives satisfactory proof of loss, except in the following cases:

- If a court has ordered your dependent to undergo medical or psychological evaluation or treatment, UBH will pay the provider directly;
- If you request in writing that the payments be made directly to a provider. You request this when you complete the claim form.

Once UBH makes these payments it satisfies our obligation.

UBH will send an Explanation of Benefits (EOB) to you. The EOB explains how UBH considered each of the Non-Network charges submitted for payment. If your claims are denied or denied in part, UBH will send a written explanation.

Any benefits continued for your dependents after your death will be paid to one of the following:

- Your surviving spouse;
- Your dependent child who is not a minor, if there is not a surviving spouse;
- A provider of care who makes charges to your dependents for Covered Services and Supplies;
- The legal guardian of your dependent.

## **Benefit Determinations**

### **Pre-service Claims**

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

### **Concurrent Care Claims**

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

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

### **Post-service Claims**

Post-service claims are those claims that are filed for payment of benefits after Behavioral Health Services have been received. If your post-service claim is denied, you will receive a written notice from

UBH within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UBH will notify you within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend the claim until all information is received.

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

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

### **Urgent Claims that Require Immediate Attention**

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

You will receive notice of the benefit determination in writing or electronically within 72 hours after UBH receives all necessary information, taking into account the seriousness of your condition.

Notice of denial may be oral with a written or electronic confirmation to follow within three days.

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

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

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

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

### **Questions or Concerns about Benefit Determinations**

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

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



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## Your Rights to an Appeal Review

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

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

If you have questions after reviewing the following information, please call **1-866-859-0505**.

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### How to Initiate an Internal Appeal Review through UBH

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

United Behavioral Health  
Appeals & Complaint Unit  
P.O. Box 411517  
St Louis, MO 63141-3517  
1-866-859-0505

Your appeal request should include the following:

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

#### Terms and Definitions

- A "Clinical Appeal" is for matters based on medical necessity, treatment, or clinical appropriateness, including the determination as to whether a treatment is experimental and investigational.
- An "Administrative Appeal" is for matters based on benefit coverage limits, eligibility, and Plan exclusions.

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

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## The First Level Appeal Process – For Clinical and Administrative Appeals

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### Non-Urgent Process

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

### Urgent Process

If your first level appeal request was an urgent review, and you remain dissatisfied with the outcome of that review, you may request a voluntary external review as described below.

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## The Second Level Appeal Process – For Clinical and Administrative Appeals

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### Non-Urgent Process

If your first level appeal request was a non-urgent review, and you remain dissatisfied with the outcome of that review, you may request a second level non-urgent appeal. This request must be made within one hundred and eighty (180) calendar days of the date you received notification from UBH of the outcome of your first level appeal. To request a second level non-urgent appeal, contact UBH at the address listed above. UBH will notify you or your authorized representative and your health care provider of the appeal resolution in writing within thirty (30) calendar days of the receipt of your request. If this is an appeal of services you have not yet received, UBH will complete the review and notify you of the outcome within fifteen (15) calendar days of the receipt of your request.

### Urgent Process

If your first level appeal request was an urgent review and you remain dissatisfied with the outcome of that review, you may request a second level internal review. You or your provider should call UBH as soon as possible using the phone number previously listed. An urgent appeal will be reviewed, a decision made, and you and your provider notified within seventy-two (72) hours of the receipt of your request.

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## How to Initiate a Voluntary External Review – For Clinical Appeals Only

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If you have completed your first and second level appeal options and remain dissatisfied with the outcome, you may request a voluntary external review. You must contact UBH within one hundred and eighty (180) calendar days of the date you received the final determination from UBH. To qualify for a voluntary external review, you must meet the following criteria:

- The adverse benefit determination must have been clinical in nature.
- You have not agreed to any other dispute resolution proceedings with UBH.

An Independent Review Organization (IRO) will perform an external review within thirty (30) calendar days of the receipt of your request through UBH. The IRO is an independent organization not affiliated with UBH. If your treating provider or UBH identifies the appeal as clinically urgent, the review will be completed within three (3) calendar days of the receipt of your request, with the possibility of extending to five (5) calendar days for good cause. You are not

required to bear the cost of the independent external review, including any filing fees. The decision of the IRO will be the final, binding, and conclusive decision with respect to your claim appeal. UBH and the Plan Sponsor must comply with the IRO's decision.

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### Additional Rights

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You may request copies free of charge, of any relevant documents, records, or other information UBH used to make its appeal decision. To request a copy of your record, contact UBH at the address or telephone number listed earlier in this document.

#### **Right to Exchange Information for Coordination of Benefits.**

UBH requires certain information to coordinate benefit payments, and it may have to obtain the facts from or give them to another organization or person. UBH need not tell, or obtain the consent of, any person to do this.

You must provide UBH with information it requests about other Plans. If you cannot furnish all the information it needs, UBH has the right to get this information from any source. If any other organization or person needs information to apply its coordination provision, UBH has the right to give that organization or person such information. Information can be given or obtained without your consent or the consent of any person to do this.