

Behavioral Health Benefits

Standard Plan - PPO

January 1, 2005

Insured By

United HealthCare Insurance Company

Administered By



GENERAL BOARD OF PENSION AND HEALTH BENEFITS
OF THE UNITED METHODIST CHURCH

Caring For Those Who Serve

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Certification

INSURANCE BOOKLET
for Participants of
The HealthFlex Program of the
General Board of Pension and Health Benefits of
The United Methodist Church, Incorporated in Illinois
(called the Plan Administrator/Policyholder)
insured by
UNITED HEALTHCARE INSURANCE COMPANY
Hartford, Connecticut
(called the Company)

This booklet becomes a Certificate of Insurance when the Participant has met the Eligibility requirements shown in the Certificate.

CERTIFICATE OF INSURANCE

United HealthCare Insurance Company has issued Group Policy No. GA-11100. It covers certain Participants of the Program.

The policy provides behavioral health benefits.

This Certificate of Insurance describes the benefits and provisions of the policy. Additional benefits and provisions may apply based on the requirements of:

- The state where the policy is issued.
- The state where the Participant lives.

These state benefits and provisions are described in separate Amendments. See the Plan Sponsor for details.

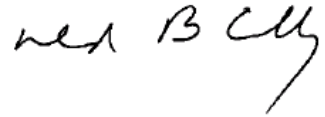
This is a Covered Person's Certificate of Insurance only while that person is insured under the policy. Dependents benefits apply only if the Participant is insured under the Program for Dependent Benefits through his or her Plan Sponsor.

This Certificate describes the Program in effect as of January 1, 2005 for participants ("Participants") enrolled in the mental and behavioral health component of the Hospitalization and Medical Expense Program, also called the HealthFlex Program (hereinafter called the HealthFlex Program). It is void if issued to any other person. For the purpose of this employee welfare benefit plan, as defined in §3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), that is a church plan, as defined in §3(33) of ERISA and §414(e) of the Internal Revenue Code ("Code"), the Internal Revenue Service considers you, pursuant to §414(e) of the Code, to be an employee of The United Methodist Church.

This Certificate replaces any and all Certificates previously issued for Participants under the Program.

NOTICE: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THIS CERTIFICATE CAREFULLY.

UNITED HEALTHCARE INSURANCE COMPANY



Ron B. Colby
Chairman and CEO

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

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

1-800-788-5614

UBH03IL

C-CE1, C-SB1, C-EL1, C-RE1, C-MH2, C-CI1, C-CB1, C-RP1, C-EM1, C-TE1, C-GL1

Schedule of Benefits

Effective Date of this Program: January 1, 2005

Behavioral Health Benefits

Standard Plan -- PPO¹

	Network	Non-Network ²
Deductibles and Copayments		
Inpatient and Intermediate Deductible	Not Applicable	\$200 Per Admission
Office Visit Copayment	\$15 Per Office Visit	Not Applicable
Mental Health and Substance Abuse Inpatient and Intermediate Non-Notification Penalties	Not Applicable	\$200 per Admission
Mental Health Outpatient Non-Notification Penalties	Not Applicable	Coinsurance reduced to 35% per Visit
Substance Abuse Outpatient Non-Notification Penalties	Not Applicable	Coinsurance reduced to 35% per Visit up to a maximum of \$20 per Visit
Mental Health Outpatient Non-Precertification Penalty	Coinsurance reduced to 70% per Visit	Not Applicable
Substance Abuse Outpatient Non-Precertification Penalty	Coinsurance reduced to 70% per Visit	Not Applicable
Out-of-Pocket Maximum	\$1,000 (excluding copayments and deductibles)	Not Applicable
Percentage Payable after Deductibles/Copayments Satisfied		
Mental Health Inpatient and Intermediate	90% with Precertification	70% with Notification

	Network	Non-Network ²
Substance Abuse Inpatient	90% with Precertification	70% with Notification up to maximum benefit of \$400 per day with Notification
Substance Abuse Intermediate	90% with Precertification	70% with Notification up to maximum benefit of \$200 per day with Notification
Mental Health Outpatient	100% after Copayment with Precertification	70% with Notification ³
Substance Abuse Outpatient	100% after Copayment with Precertification	70% up to a maximum benefit of \$40 per visit with Notification ³
Maximum Benefits		
Mental Health Calendar Year Maximum Inpatient	SMI ⁴ : Unlimited Non SMI: 45 Days	
Substance Abuse Calendar Year Maximum Inpatient	30 Days	
Mental Health Calendar Year Maximum Outpatient	SMI ⁴ : Unlimited Non SMI: 50 Visits	
Substance Abuse Calendar Year Maximum Outpatient	30 Visits	
Mental Health Lifetime Maximum	None	
Substance Abuse Inpatient Lifetime Maximum	60 Days	
Substance Abuse Outpatient Lifetime Maximum	60 Visits	

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

¹All benefits may be substituted and/or converted to alternative levels of care with care management approval.

²Non-Network, Non-Precertified services are subject to Non-Notification and Non-Precertification penalties and Utilization Review at the time a claim is submitted for payment in order to determine if the services meet the criteria for Covered Services.

³Non Network outpatient notifications are only valid for two (2) calendar years. Members must call UBH every two (2) years to request a new notification for their Non Network Provider. This is a non standard requirement.

⁴Serious Mental Illness (SMI) is defined as the following diagnoses:

- Schizophrenia
- Paranoid and other psychotic disorders
- Bipolar Disorders (Hypomanic, Manic, Depressive, and Mixed)
- Major Depressive Disorders (Single Episode or Recurrent)
- Schizoaffective Disorders (Bipolar or Depressive)
- Pervasive Developmental Disorders (including Autism)
- Obsessive-Compulsive Disorders
- Anorexia Nervosa and Bulimia
- Depression in Childhood and Adolescence
- Panic Disorder
- Post-Traumatic Stress Disorder

Eligibility

Eligible Participants

You are an eligible Participant if your Plan Sponsor, an entity, organization or corporation affiliated with the Policyholder through association with The United Methodist Church, elects coverage for your job category under an Adoption Agreement, through which the Plan Sponsor adopts and becomes affiliated with the HealthFlex Program and the Policyholder and you are an active Participant of the Plan Sponsor, in accordance with the terms of the HealthFlex Program.

Participants must reside in the United States (includes Puerto Rico).

Eligible Dependents

Dependents are:

- A Spouse: the wife or husband of an eligible Participant. A Spouse must be:
 - Married in accordance with the law of the jurisdiction in which the Participant is domiciled; or
 - The legally separated or divorced spouse of a Participant if the Participant is legally responsible by legal decree for
 - The majority of financial support for the former spouse, or
 - Specifically for the medical health care expenses of the spouse or former spouse.

Notwithstanding the foregoing, the term "Spouse" will not include common law spouses, even in states that recognize common law marriage.

- A Surviving Spouse of a deceased eligible Participant of the above participating groups
- Any unmarried child of an eligible Participant or of a covered Surviving Spouse of a deceased Participant from birth through the last day of the month the child attains age 19.
- An unmarried child under age 25 of an eligible Participant, if the child is a registered student in regular full-time attendance at school. The child must be mainly dependent on the Participant for care and support.

Such child is considered eligible until:

- The last day of the month following drop-out or withdrawal from the college, university or post high school institution;
- The last day of the month the Dependent Child attains age 25, even if still in attendance at a school; or
- The last day of the third month (including the month the student graduates) after graduation from the college, university or post high school institution.

Any unmarried child, without regard to the child's age, who is not self supporting due to mental or physical impairment.

The Participant must give United Behavioral Health (UBH) proof, when requested, that the child meets these conditions. UBH will ask for proof once a year. Children who are not self-supporting must be mainly dependent on the Participant for care and support. These children must have become incapable of self-support either:

- Before reaching age 19; or
- While covered as a Dependent under the Program.

Child includes the following:

- Any such child living with you in a parent child-relationship, primarily dependent upon you for support and care for whom you have legal guardianship.
- A stepchild who resides in the eligible Participant's home.
- A child for which you are the legal guardian.
- A legally adopted child. (A child is considered legally adopted on the earlier of the date of placement or the date the legal adoption proceedings have been started.)
- A natural or legally adopted child, under age 19, who is not living with the Participant, and for whom the Participant is responsible by legal decree for:
 - The majority of financial support of the child; or
 - Specifically for the mental health care expenses of the child (through a Qualified Medical Child Support Order).

The following will not be considered eligible Dependents:

- A married child of any age.
- A grandchild or foster child who has not been legally adopted by the Participant.
- A natural or legally adopted child under age 19 who is living with a former husband or wife at another location, and for whom the Participant is not responsible by legal decree for:
 - The majority of financial support of the child; or
 - Specifically for the mental health care expenses of the child (through a Qualified Medical Child Support Order).
- A natural, legally adopted or step-child of a husband or wife of an eligible Participant, who is not living with the Participant or for whom another party is legally responsible for:

- The majority of financial support of the child; or
- Specifically for the mental health care expenses of the child (through a Qualified Medical Child Support Order).

Dependents must reside in the United States.

Cost of Coverage

The coverage under this Program may be contributory. This means that Participants may need to make contributions toward the cost of coverage.

Enrollment Requirements

Enrollment Date

The date the person is enrolled under this Program.

Participant Coverage

A Participant enrolls for Participant coverage by:

- completing an enrollment form, and
- giving the form to the Plan Sponsor.

Cafeteria Plan Rules

Effect of Section 125 Regulations on this Plan

The Program is administered in accordance with Section 125 of the Code and the regulations promulgated thereunder (Section 125 Regulations), through what is commonly known as a cafeteria plan. In accordance with the Section 125 Regulations, you may agree to have the cost of your benefits deducted from your salary on a pre-tax basis. Otherwise you will receive the full amount of your taxable earnings.

Coverage Elections

In accordance with the Section 125 Regulations, you are generally allowed to enroll for or change coverage only during each annual benefit enrollment or election period, typically each November. A plan may permit a Participant to revoke an election during a period of coverage and to make a new election only as determined by the plan. Section 125 does not require a plan to permit any of these changes. However, the following events will allow you to enroll or change coverage within 30 days of the event during a period of coverage (a Plan Year):

- **Change in Status Event:** A change in coverage due to the following changes in status:
 - Change in legal marital status due to marriage, death of a Spouse, divorce, annulment or legal separation;
 - Change in number of Dependents due to birth, adoption, placement for adoption or death of a Dependent;
 - Change in employment status of Participant (this excludes an appointment change for clergy), Spouse or Dependent due to termination or start of employment;
 - Changes in employment status of the Participant, Spouse or Dependent resulting in eligibility or ineligibility for coverage;
 - Changes which cause a Dependent to become eligible or ineligible for coverage (e.g., reaching a limiting age, or ceasing to be a full-time student); and

- Significant change in coverage such as the loss or change of a coverage option as a result of moving to a new zip code area (e.g., moving out of the coverage area for a managed care option);
- HIPAA Special Enrollment events (see below).

Any changes in coverage must be consistent with the Change in Status Event.

- **Court Order:** A change in coverage due to and consistent with a court order that requires the Participant or other person to cover a Dependent. See the section entitled *Qualified Medical Child Support Orders* for more information.
- **Medicare Eligibility or Entitlement:** The Participant, Spouse or Dependent cancels or reduces coverage due to entitlement to Medicare, or enrolls or increases coverage due to loss of Medicare Eligibility.
- **FMLA:** Certain required circumstances under the Family and Medical Leave Act where applicable to your employer.
- **Mid-year Program Changes:** e.g., significant changes in the cost of coverage or significant curtailment of coverage during a Program year.
- **HIPAA Special Enrollment:** You may make a coverage election change if:
 - The plan of your Spouse or Dependent incurs a change such as adding or deleting a benefit option;
 - The plan of your Spouse or Dependent allows election changes due to Special Enrollment;
 - Your Spouse or dependent has a Change in Status Event, Court Order or Medicare Eligibility or Entitlement;
 - Your Spouse or Dependent loses the other health coverage, as defined under HIPAA, because he or she is no longer eligible (e.g., through an employment status change, limiting age, etc.) or because the employer failed to pay the required premium or he or she completes the COBRA or other continuation coverage period;
 - You decline coverage under the Program for yourself because you have other health coverage or you have COBRA or other continuation coverage, then you lose the other health coverage because you are no longer eligible (e.g., through an employment status change, divorce, death of a spouse etc.) or because the employer failed to pay the required premium or you complete the COBRA or other continuation coverage period;
 - You gain a new Dependent due to marriage, birth, adoption, or placement for adoption or legal guardianship; or
 - You decline coverage under the Program for yourself (or your Spouse or Dependent) because you (or your Spouse or Dependent) have other health coverage, then you (or your Spouse or Dependent) reach a lifetime limit for all benefits under the other health coverage.

For More Information

For more information about the effect of the Section 125 Regulations on your benefits under the Program contact your Plan Sponsor or the General Board.

Qualified Medical Child Support Order

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

If the Participant is not already enrolled, the Participant may also enroll as a timely enrollee at the same time.

Special Provision for Newborn Children

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

Behavioral Health Benefits

What This Program Pays

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

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

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

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

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

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

Behavioral Health Services are services and supplies which are:

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

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

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

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

Notification Requirements and Utilization Review

To receive the higher level of benefits under this Program (called the Network level) and not incur the penalties shown below, the Covered Person must call United Behavioral Health (UBH) before inpatient Behavioral Health Services are given. **The toll-free number is 1-800-788-5614. UBH is ready to take the Covered Person's call 7 days a week, 24 hours a day.** This call starts the utilization review process. The Covered Person will be referred to a Network Provider who is experienced in addressing his/her specific issues.

Benefits under this Program are reduced as follows if the Covered Person does not get a referral from UBH to a Network Provider before inpatient Behavioral Health Services are given:

- Benefits are payable at the Non-Network level, as shown in **Schedule of Benefits**.
- Benefits are subject to a Non-Notification Deductible. The amount of the Non-Notification Deductible will never be more than the Covered Expense. The amount is shown in **Schedule of Benefits**.
- Benefits are subject to Utilization Review at the time a claim is submitted for payment in order to determine if the services incurred are Covered Services.

If the Covered Person is not satisfied with a Network Provider, he/she may call UBH and ask for a referral to another Network Provider. The Covered Person may do this more than once, but he/she will only be referred to one Network Provider at a time.

UBH performs a Utilization Review to determine whether the service or supply is a Covered Service. The Covered Person and his/her Provider decide which Behavioral Health Services are given, but this Program only pays for Covered Services.

Emergency Care

Emergency Care does not require a referral from UBH to a UBH Network Provider.

When Emergency Care is required for MHSA Treatment, the Covered Person (or his/her representative or his/her Provider) must call UBH within one day after the Emergency Care is given. If it is not reasonably possible to make this call within one calendar day, the call must be made as soon as reasonably possible.

When the Emergency Care has ended, the Covered Person must get a referral from UBH before any additional services will be covered at the Network level. If the Covered Person does not get a referral as required, benefits for any additional services are payable at the Non-Network level.

Copayments, Coinsurance and Deductibles

Before behavioral health benefits are payable, each Covered Person must satisfy certain Copayments, Coinsurance and/or Deductibles.

A Copayment is the amount of Covered Expenses the Covered Person must pay to a Network Provider at the time services are given. Copayments are not counted toward any Deductible. Behavioral Health Services which require a Copayment are not subject to a Deductible.

A Deductible is the amount of Covered Expenses the Covered Person must pay before behavioral health benefits are payable.

After the Deductible has been met, Coinsurance is the amount of Covered Expenses payable at the percentage shown in **Schedule of Benefits**.

The amount of each Copayment/Deductible is shown in **Schedule of Benefits**. A Covered Expense can only be used to satisfy one Copayment or Deductible.

Office Visit Copayment

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

Non-Network Inpatient Deductible

The Non-Network Inpatient Deductible applies to each confinement in a Non-Network Provider Facility.

Non-Notification Deductible

The Non-Notification Deductible applies to Covered Expenses if the Covered Person does not call UBH before obtaining Behavioral Health Services.

Out-of-Pocket Maximum

Out-of-Pocket Maximum is the maximum amount (excluding Copayments and Deductibles) a Covered Person will pay for services in a plan year.

Maximum Benefit

The Maximum Benefit payable for each Covered Person is shown in **Schedule of Benefits**. This maximum applies to each Covered Person's lifetime.

The Maximum Benefit includes any amount paid under the mental and behavioral health benefits component of the Plan Sponsor's group health plan, the HealthFlex Program, in effect on the day before the effective date of this Program.

Extended Benefits

Extended Benefits are payable for a Totally Disabled Covered Person for up to 3 months. Extended Benefits are only payable for Behavioral Health Services given during the 3-month period after the person's coverage ends.

The person must be continuously Totally Disabled due to the same cause from the date coverage ends until the date Behavioral Health Services are given.

Extended Benefits are only payable for Behavioral Health Services given for the injury or sickness causing Total Disability.

What's Not Covered - Exclusions

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

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

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

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

- Treatment or services, except for the initial diagnoses, for a primary 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 the acute stabilization of the Covered Person and returning the Covered Person back to his or her baseline levels of individual functioning. Care is determined to be custodial when:
 - it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the Covered Person's competent functioning in activities of daily living; or
 - it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the Covered Person to function outside a structured

environment. This applies to Covered Persons for whom there is little expectation of improvement in spite of any and all treatment attempts.

Covered Persons whose repeated and volitional non-compliance with treatment recommendations result in a situation in which there can be no reasonable expectation of a successful outcome.

- Neuropsychological testing when used for the diagnosis of attention deficit disorder.
- Examinations or treatment, unless it otherwise qualifies as Behavioral Health Services, when:
 - required solely for purposes of career, education, sports or camp, travel, employment, insurance, 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 the National Institutes of Health.
- Nutritional Counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.
- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment rendered by unlicensed Providers (except as required by law), or which are outside the scope of the Providers' licensure.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
- Light boxes and other equipment including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while confined in a facility.
- Surgical procedures including but not limited to sex transformation operations.
- Smoking cessation related services and supplies.
- Travel or transportation expenses unless UBH has requested and arranged for Covered Person to be transferred by ambulance from one facility to another.
- Services performed by a Provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the Provider may perform on himself or herself.
- Services performed by a Provider with the same legal residence as the Covered Person.
- Behavioral Health Services for which the Covered Person has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Program.
- Charges in excess of any specified Program limitations.
- Any charges for missed appointments.

- Any charges for record processing except as required by law.
- **Services Provided Under Another Plan.** Services or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes but is not limited to coverage required by workers' compensation, no-fault auto, or similar legislation. If coverage under workers' compensation or a similar law is optional for Covered Person because Covered Person could elect it or could have it elected for him or her, benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected.
- Behavioral Health Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country when Covered Person is legally entitled to other coverage.
- Treatment or services received prior to Covered Person being eligible for coverage under the Program or after the date the Covered Person's coverage under the Program ends.

Network Provider Charges Not Covered

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

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

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

Claims Information

How to File a Claim

A claim form does not need to be filed when a Network Provider is used.

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

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

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

- The Participant's name and member ID number.
- The Plan Administrator's name and contract number (11100).
- The patient's name.
- The diagnosis.

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

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

When Claims Must be Filed

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

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

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

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

How and When Claims Are Paid

UBH will make a benefit determination as set forth below. Benefits will be paid to the covered Participant as soon as United Behavioral Health receives satisfactory proof of loss, except in the following cases:

- If the covered Participant has financial responsibility under a court order for a Dependent's medical care, United Behavioral Health will make payments directly to the Provider of care.
- If United Behavioral Health pays benefits directly to Network Providers.
- If the covered Participant requests in writing that payments be made directly to a Provider. A covered Participant does this when completing the claim form.

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

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

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

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

Benefit Determinations

Pre-service Claims

Pre-service claims are those claims that require notification or approval prior to receiving Behavioral Health Services. If the Covered Person's claim was a pre-service claim, and was submitted properly with all needed information, the Covered Person will receive written notice of the claim decision from UBH within 15 days of receipt of the claim. If the Covered Person filed a pre-service claim improperly, UBH will notify the Covered Person of the improper filing and how to correct it within five days after the pre-service claim was received. If

additional information is needed to process the pre-service claim, UBH will notify the Covered Person of the information needed within 15 days after the claim was received, and may request a one-time extension not longer than 15 days and pend the Covered Person's claim until all information is received. Once notified of the extension, the Covered Person then has 45 days to provide this information. If all of the needed information is received within the 45-day time frame, UBH will notify the Covered Person of the determination within 15 days after the information is received. If the Covered Person does not provide the needed information within the 45-day period, the claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

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

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

Post-service Claims

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

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

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

Urgent Claims that Require Immediate Attention

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

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

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

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

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

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

Questions or Concerns about Benefit Determinations

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

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

How to Appeal a Claim Decision

If the Covered Person disagrees with a claim determination after following the above steps, he or she can contact UBH in writing to formally request an appeal. If the appeal relates to a claim for payment, the request should include:

- The patient's name and the identification number.
- The date(s) of service(s).
- The Provider's name.
- The reason the Covered Person believes the claim should be paid.
- Any documentation or other written information to support the request for claim payment.

The Covered Person's first level appeal request must be submitted to UBH within 180 days after he or she receives a claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If the appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. UBH may consult with, or seek the participation of, medical experts as part of the appeal resolution process. The Covered Person consents to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, the Covered Person has the right to reasonable access to and copies of all documents, records, and other information relevant to his or her claim for benefits.

Appeals Determinations

First Level Pre-service and Post-service Claim Appeals

The Covered Person will be provided written or electronic notification of the decision on the appeal as follows:

For appeals of **pre-service claims** as identified above, the first level appeal will be conducted and the Covered Person will be notified of the decision within 15 days from receipt of a request for appeal of a denied claim.

For appeals of **post-service claims** as identified above, the first level appeal will be conducted and the Covered Person will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim.

For procedures associated with urgent claims, see ***Urgent Claim Appeals That Require Immediate Action*** below.

If the Covered Person is not satisfied with the first level appeal decision, he or she has the right to request a second level appeal, see ***Second Level Pre-service and Post-service Claim Appeals*** below.

Please note that UBH's decision is based only on whether or not benefits are available under the policy for the proposed treatment or procedure.

Second Level Pre-service and Post-service Claim Appeals

If the Covered Person is not satisfied with the first level appeal decision, the Covered Person has the right to request a second level appeal. The second level appeal request must be submitted to UBH within 60 days from receipt of the first level appeal decision.

For appeals of **pre-service claims**, the second level appeal will be conducted and the Covered Person will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of **post-service claims**, the second level appeal will be conducted and the Covered Person will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Urgent Claim Appeals that Require Immediate Action

An appeal may require immediate action if a delay in treatment could significantly increase the risk to the Covered Person's health, or the ability to regain maximum function. In these urgent situations:

The appeal does not need to be submitted in writing. The Covered Person or his or her Physician should call UBH as soon as possible.

UBH will provide the Covered Person with a written or electronic determination within 72 hours following receipt of the request for review of the determination, taking into account the seriousness of the Covered Person's condition.

Legal Actions

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

Incontestability of Coverage

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

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

Information and Records

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

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

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

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

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

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

Coordination of Benefits

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

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

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

Definitions

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

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

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

to benefits payable under Other Plans.

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

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

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

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

How Coordination Works

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

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

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

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

Which Plan Pays First

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

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

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

If the other plan does not have a birthday rule, but instead has a rule based on the gender of the parent,

and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

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

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

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

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

Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The Company may pay the plan or organization or person for the amount of benefits that the Company determines it should have paid. That amount will be treated as if it was paid under this Program. The Company will not have to pay that amount again.

Right of Recovery

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

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

Recovery Provisions

Refund of Overpayments

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

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

The refund equals the amount the Company paid in excess of the amount it should have paid under this Program.

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

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

Reimbursement of Benefits Paid

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

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

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

Subrogation

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

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

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

Effect of Medicare and Government Plans

Medicare

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

When This Program Pays Primary to Medicare

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

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

When Medicare Pays Primary to this Program

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

- Eligibility is due to disability and the Participant does NOT have "current employment status" with the Plan Sponsor as defined by federal law and determined by the Plan Sponsor.
- Eligibility for Medicare is due to end stage renal disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary.
- Eligibility for Medicare is due to age, and the Participant or a Dependent of such Participant continues to work for or returns to work with an employer who has fewer than 20 employees (under the small employer exception to the Medicare Secondary Payer rules).

See **How this Program Pays When Medicare is Primary.**

Important! - Medicare Enrollment Requirements

When this Program pays benefits first, without regard to Medicare, and the Covered Person wants Medicare to pay after this Program, the Covered Person must enroll for Medicare Parts A and B. If the Covered Person does not enroll for Medicare when he or she is first eligible, the Covered Person must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Program.

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

How This Program Pays When Medicare Is Primary

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

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

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

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

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

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

- The person is not enrolled for Medicare Parts A and B. Benefits are determined as if the person were covered under Medicare Parts A and B.
- The expenses are paid under another employer's group health plan which is primary to Medicare. Benefits are determined as if benefits under that other employer's plan did not exist.

- The person is enrolled in a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) to receive Medicare benefits, and receives unauthorized services (out-of-plan services not covered by the HMO/CMP). Benefits are determined as if the services were authorized and covered by the HMO/CMP.

Government Plans (other than Medicare and Medicaid)

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

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

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

Termination of Coverage

Participant Coverage

Participant coverage ends on the earliest of the following:

- The day this Program ends.
- The last day of the month in which employment stops. See **Disability** and **Leave of Absence or Temporary Layoff** below.
- The day the person stops being an eligible Participant.
- The last day of a period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made when due.

Disability

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

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

Leave of Absence or Temporary Layoff

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

Dependent Coverage

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

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

Coverage for an individual Dependent ends on the earlier of:

- The day the Dependent becomes covered as an Participant under this Program.
- The day the Dependent stops being an Eligible Dependent.

Continuation of Coverage for Incapacitated Children

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

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

The Participant must give the Company proof that the child meets these conditions when requested. The Company will not ask for proof more than once a year.

Glossary

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

Adoption Agreement

A written agreement between a Plan Sponsor and the Plan Administrator/Policyholder whereby the Plan Sponsor agrees to participate, contribute, and sponsor Group Policy No. GA-11100, through the HealthFlex Program for its eligible Participants.

Behavioral Health Services

Services and supplies which are:

- Covered Services for MHSA Treatment.
- Given while the Covered Person is covered under the plan.
- Given by one of the following providers:
 - Physician;
 - Psychologist;
 - Licensed Counselor;
 - Provider;
 - Hospital;
 - Treatment Center; or
 - Pastoral Counselors.

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

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

Calendar Year

A period of one year beginning with a January 1.

Course of Treatment

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

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

Covered Expenses

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

Covered Person

The Participant and the Participant's Spouse and Dependent children who are covered under this Program.

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 Program Pays," and not excluded under the section titled "What's Not Covered - Exclusions."

Emergency Care

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

HealthFlex Program

The Hospitalization and Medical Expense Program maintained by the Plan Administrator on behalf of its Participants. The Program is a church plan as defined in Section 3(33) of ERISA and 414(e) of the Code.

Hospital

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

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

Licensed Counselor

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

Medicare

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

MHSA Treatment

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

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

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

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

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

Prescription Drugs are not considered MHSA Treatment.

Network Provider

A Provider which participates in the United Behavioral Health network. Network Providers are sometimes called participating providers.

Non-Network Provider

A Provider which does not participate in the United Behavioral Health network. Non-Network Providers are sometimes called non-participating providers.

Participant

The term Participant means a full-time Employee of the General Board, a full-time Employee of a Plan Sponsor eligible under the terms of the Program who is currently enrolled in the Program. For the purposes of this definition the term Employee shall mean a person who is described as an employee of a church in Sections 414(e)(3) or 7701(a)(20) of the Code, who is a clergyperson serving The United Methodist Church, or who is a common law employee of the General Board or a Plan Sponsor, including a former Employee who has retired. For the purposes of this definition the term full-time means, for a lay employee, that he or she is regularly scheduled to work 30 hours per week for six consecutive months or more with his or her Plan Sponsor, and for a clergy employee, that he or she is appointed with an annual conference of The United Methodist Church to at least ½ time service. The term Participant also includes retired Employees of the General Board and Plan Sponsors who are under the age of 65.

Physician

A legally qualified:

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

Plan

The group policy or policies issued by the Company which provide the benefits described in this Certificate of Insurance.

Program

The employee welfare benefit plan, as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), called the Hospitalization and Medical Expense Program, also called HealthFlex, that is a church plan, as defined in Section 3(33) of ERISA, maintained by the General Board on behalf of its participating Plan Sponsors and its and their Participants, the mental health benefits portion of which is governed by the group policy or policies issued by the Company which provide the benefits described in this Certificate of Insurance.

Provider

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

Psychologist

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

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

Reasonable Charge

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

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

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

Total Disability or Totally Disabled

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

Treatment Center

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

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

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

UBH

United Behavioral Health, the administrator of benefits under the Program.

Utilization Review

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

End of Certificate

Continuation of Coverage During Family and Medical Leave (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period to eligible employees (under the terms of the FMLA) for certain family and medical reasons. This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See the Plan Sponsor to find out details about how the FMLA and this continuation may apply to you.

Reasons for Taking Leave

FMLA leave must be granted for any of the following reasons:

- Care of a child after birth.
- Care of a child after placement of that child with the employee for adoption or foster care.
- Care of the employee's spouse, child or parent (but not a parent-in-law) who has a serious health condition.
- A serious health condition that makes the employee unable to work.

Employee Eligibility

To be eligible for FMLA benefits, all of the following must be true:

- The employee must work for a covered employer.
- The employee must have worked for the employer for at least 12 months.
- The employee must have worked at least 1,250 hours over the previous 12 months.
- The employee must work at a location where at least 50 employees are employed by the employer within 75 miles.

Advance Notice and Medical Certification

The employee must provide advance notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- If the need for the leave is unforeseen, notice must be given as soon as practicable.
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require a second or third opinion (at the employer's expense) and a fitness for duty report to return to work.

Continuation of Coverage, Job Benefits and Protection

For the duration of a FMLA leave, the employer must maintain the employee's coverage. The employee may continue the Program benefits for himself or herself and his or her Dependents on the same terms as if the employee had continued to work. The employee must pay the same contributions toward the cost of the coverage that he or she made while working.

If the employee fails to make the payments on a timely basis, the employer, after giving you written notice, can end the coverage during the leave if payment is more than 30 days late.

- Upon return from a FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.
- The use of a FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

See the employer for details about continuing group coverage other than the Program benefits.

Intermittent Leave

Under some circumstances, an employee may take a FMLA leave intermittently which means taking a leave in blocks of time, or by reducing his or her normal weekly or daily work schedule.

- Where a FMLA leave is for birth or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval.
- A FMLA leave may be taken intermittently whenever it is medically necessary to care for a seriously ill family member, or because the employee is seriously ill and unable to work.

Substitution of Paid Leave

Subject to certain conditions, employees or employers may choose to use accrued **paid** leave (such as sick or vacation leave) to cover some or all of the FMLA leave. The employer is responsible for designating if paid leave used by the employee counts as a FMLA leave, based on information provided by the employee. In no case can an employee's paid leave be credited as a FMLA leave **after** the leave has been completed.

Spouses Who Work for the Same Employer

Spouses employed by the same employer are jointly entitled to a **combined** total of 12 work weeks of family leave for the birth of a child or placement of a child for adoption or foster care, and to care for such child or to care for a parent who has a serious health condition.

Reenrollment after a FMLA Leave

If any or all of an employee's coverages end while the employee is on a FMLA leave, the employee can reenroll for coverage when he or she returns to work from the FMLA leave.

The employee and any Dependents will be considered timely enrollees if the employee reenrolls within 31 days from the date he or she returns to work.