STATE OF OHIO

Behavioral Health Benefits

Effective: July 1, 2015 – June 30, 2016

Summary Plan Document (SPD)

Administered By

OPTUM™

BEHAVIORAL SOLUTIONS

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Certification

Plan Description

for Employees of:

State of Ohio

(called the Employer)

Group Policy No. GA 00832

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

This Plan Description describes the Plan in effect as of July 1, 2015 to June 30, 2016.

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

The behavioral health benefits described in this Plan are administered by United Behavioral Health operating under the brand Optum."

Primary Telephone Number: 1-800-852-1091

Schedule of Benefits

Behavioral Health Benefit Plan Design	
Effective July 1, 2015	
Administered by Optum Behavioral Solutions 1-800-852-1091	
COPAYMENTS	
Outpatient in-network	$20
Outpatient out-of-network	$30; Balance billing applies
Emergency Room	$75 (deductible and coinsurance may apply)
Intensive outpatient care in-network	$20
Intensive outpatient care out-of-network	$30; balance billing applies
DEDUCTIBLES	
Single in-network	$200 combined with medical
Family in-network	$400 combined with medical
Single out-of-network	$400 combined with medical
Family out-of-network	$800 combined with medical
PLAN COINSURANCE %	
Outpatient in-network	100% after office visit copay 80% for some services
Outpatient out-of-network	60% of fee schedule after copayment Balance billing applies
Inpatient in-network	80% after deductible
Inpatient out-of-network	60% of fee schedule after deductible $350 penalty if not pre-authorized Balance billing applies
OUT-OF-POCKET MAXIMUM	
Single in-network	$1,500 combined with medical
Family in-network	$3,000 combined with medical
Single out-of-network	$3,000 combined with medical
Family out-of-network	$6,000 combined with medical
OTHER	
Day Limits	None
Annual Limits	None
Lifetime Limits	None
Benefit Limits	Some

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Eligibility

Eligible Employees and Dependents

All Employees and dependents that are enrolled in the State of Ohio medical plan are considered eligible.

Effective Date of Employee and Dependent Coverage

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

Qualified Medical Child Support Order

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

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

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

Special Provision for Newborn Children

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

Behavioral Health Benefits

What This Plan Pays

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

To receive benefits, the Covered Person should call Optum Behavioral Solutions before Covered Expenses are incurred. (See Notification Requirements and Utilization Review.)

Each Covered Person must satisfy specific Copayments before any payment is made for certain Behavioral Health Services. The behavioral health benefit will then pay the percentage of Covered Expenses shown in the 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 to the Covered Person. Optum, at its discretion, will calculate Covered Expenses following evaluation and validation of all Provider billings in accordance with the methodologies:

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

Behavioral Health Services are services and supplies which are:

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

Autism Spectrum Disorders - The Plan will cover medically necessary services provided for the diagnosis and treatment of autism spectrum disorders that have been diagnosed by a qualified DO/MD/PHD with expertise and training in autism, pursuant to the requirements of the plan, including without limitation:

- Professional services by providers – including care by appropriately credentialed, licensed or certified psychiatrists, psychologists, social workers, and board-certified behavior analysts.
- Habilitative and rehabilitative care, including, but not limited to, applied behavioral analysis by a Board-Certified Behavior Analyst (BCBA) as defined by law.

Additional Autism Spectrum Disorder coverage information is available at: **www.liveandworkwell.com**

Applied Behavioral Analysis Services (ABA) – Services related to the ABA are listed below based on medical necessity and managed under Optum Behavioral Solutions coverage determination guidelines. Services must be provided by, or under the direction of, an experienced network psychiatrist and/or an experienced licensed psychiatric provider or conjoint supervision of paraprofessionals by a BCBA (or qualified licensed clinician) and include the following:

- Skills assessment by BCBA or qualified licensed clinician;
- Conjoint supervision of paraprofessionals by BCBA (or qualified licensed clinician) with clients present;
- Treatment planning conducted by a BCBA (or qualified licensed clinician);

- Direct ABA services by a BCBA or licensed clinician; and
- Direct ABA services by a paraprofessional or BCBA (if appropriately supervised).

ABA services must be pre-authorized. Treatment that is not pre-authorized may result in no coverage.

ABA services are limited to 20 hours per week, including services provided for a consultation/assessment/development/oversight of ABA treatment plans. ABA services that exceed the 20 hour per week limit will result in the denial of services over the plan maximum for that specific week.

Psychiatric Services – Psychiatric services for Autism Spectrum Disorders that are provided by, or under the direction of, an experienced psychiatrist and/or an experienced licensed psychiatric provider and are focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning, include:

- Diagnostic evaluations and assessment
- Treatment planning
- Referral services
- Medication management
- Inpatient / 24-hour supervisory care
- Partial Hospitalization/Day Treatment
- Intensive Outpatient Treatment
- Residential Treatment Facility Services
- Individual, family, therapeutic group, and provider-based case management services
- Psychotherapy, consultation, and training session for parents and paraprofessional and resource support to family
- Crisis Intervention
- Transitional Care

Note: All ABA services must be coordinated with Optum Clinical Team and members must use Optum's contracted providers.

Behavioral health services also include, but are not limited to, the following:

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

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

Notification Requirements and Utilization Review

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

If the Covered Person is not satisfied with a Network Provider, he or she may call Optum and ask for a referral to another Network Provider. An out-of-network benefit may apply, if an out-of-network provider has not been screened by Optum. This means your out-of-pocket costs for services will be higher.

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

Emergency Care

Emergency Care does not require a referral from Optum to an Optum Network Provider. Emergency services are typically covered by your medical plan. No pre-authorization is required for emergency room services.

When Emergency Care is required for mental health and substance abuse (MHSA) Treatment, the Covered Person (or his/her representative or his/her Provider) should call Optum within one day after the Emergency Care is given, to report an admission or arrange for follow-up care. If it is not reasonably possible to make this call within one calendar day, the call should be made as soon as reasonably possible.

Cost Sharing

Covered Person's must satisfy specific Deductible Amounts and/or Copayments before some behavioral health benefits are payable.

A **Deductible** is the amount you must pay before your plan starts to pay for benefits (except for routine office visits). A Deductible is the amount of expenses that must be paid out of pocket before your plan will begin to pay for services received (except for routine office visits). Your deducible amount may accumulate from paying medical expenses, behavioral health expenses, or a combination of both.

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

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

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

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

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

Maximum Benefit

There are no maximum benefit limitations under the Plan.

What's Not Covered (Exclusions to the State of Ohio's Health Plan)

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

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

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM).
- Prescription drugs or over the counter drugs and treatments. (Refer to your prescription drug plan to determine whether prescription drugs are a covered benefit).
- ABA services that are provided in a school. For example, tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act; educational / behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
- Mental health services as treatment for a primary diagnosis of binge eating disorders or gambling disorders.
- Services or supplies for MHSA Treatment that, in the reasonable judgment of Optum 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 Optum's Level of Care Guidelines or best practices as modified from time to time.

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

- Treatment or services, except for the initial diagnoses, for a primary diagnosis of Mental Retardation (317,318,319), Learning, Motor Skills, and Communication Disorders (315), Pervasive Developmental Disorder (299), Conduct Disorder (312), Dementia (290, 294), Sexual, Paraphilia, and Gender Identity Disorders (302), and Personality Disorders (301), as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by Optum.

- Unproven, investigational or experimental services. Services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted stands of medical practice in the United States. If a service, treatment, or a device is the only available treatment for a particular condition, it will not automatically result in a Covered Service if it is considered to be unproven, investigational or experimental.

- Custodial care except for the acute stabilization of the Covered Person and returning the Covered Person back to his or her baseline levels of individual functioning. Care is determined to be custodial when:

  - it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the Covered Person's competent functioning in activities of daily living; or

  - it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the Covered Person to function outside a structured environment. This applies to Covered Persons for whom there is little expectation of improvement in spite of any and all treatment attempts.

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

- Neuropsychological testing when used for the diagnosis of attention deficit disorder.

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

  - required solely for purposes of career, education, sports or camp, travel, employment, insurance or adoption;

  - ordered by a court except as required by law;

  - conducted for purposes of medical research;

  - required to obtain or maintain a license of any type; and

  - herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

- Nutritional counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.
- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment rendered by unlicensed Providers, including pastoral counselors (except as required by law), or which are outside the scope of the Providers' licensure.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
- Light boxes and other equipment including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while confined in a facility.
- Surgical procedures including but not limited to sex transformation operations.
- Smoking cessation related services and supplies.
- Travel or transportation expenses unless Optum has requested and arranged for Covered Person to be transferred by ambulance from one facility to another. Services performed by a Provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the Provider may perform on himself or herself. Services performed by a Provider with the same legal residence as the Covered Person.
- Behavioral health services for which the Covered Person has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- Charges in excess of any specified Plan limitations.
- Any charges for missed appointments.
- Any charges for record processing except as required by law.
- Services provided under another health 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 he/she could elect it or could have it elected. Benefits will not be paid if coverage would have been available or elected under worker’s compensation or a similar law for the Covered Person.

- Behavioral Health Services received as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country when Covered Person is legally entitled to other coverage.
- Treatment or services received prior to Covered Person being eligible for coverage under the Plan or after the date the Covered Person's coverage under the Plan ends.

Network Provider Charges Not Covered

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

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

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

Out-of-Network (OON) Provider Charges

If the medical plan provides out-of-network benefits, you may have access to Out-of-Network benefits through Optum Behavioral Solutions, but at a higher cost to you.

The amount the plan pays for covered services is based on the contracted **allowed amount**. If an out-of-network provider charges more than the contracted **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the contracted **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)

If the Plan provides a benefit for out-of-network inpatient facility services (e.g., hospitalization, partial hospitalization, residential, day or structured outpatient treatment facilities), you must obtain pre-authorization before obtaining medical care. If you do not, you will be required to pay a $350 penalty.

Please contact Optum before receiving services to ensure the highest level of benefits.

Claims Information

How to File a Claim

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

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

- Obtain a claim form from the Employer, the Plan Administrator or Optum Behavioral Solutions.

- Complete the Employee portion of the form.
- Have the Provider complete the Provider portion of the form.
- Send the form and bills to the address shown on the form. Make sure the bills and the form include the following information:
  - The Employee's name and social security number
  - The Employer's name and contract number (00832)
  - The patient's name
  - The diagnosis
  - The date the services or supplies were incurred
  - The specific services or supplies provided

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

Where to File a Claim

Optum Behavioral Solutions Claim Appeal
P.O. Box 30760
Salt Lake City, UT 84130-0760

When Claims Must Be Filed

The Covered Employee must give Optum written proof of loss within 12 months after the date the expenses are incurred.

Optum will determine if sufficient 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 Optum as soon as was reasonably possible.

How and When Claims Are Paid

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

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

Optum Behavioral Solutions will send an Explanation of Benefits (EOB) to the Covered Employee. The EOB will describe how Optum considered each of the charges submitted

for payment. If any claims are denied or denied in part, the Covered Employee will receive a written explanation.

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

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

Benefit Determinations

Pre-Service Claims - Are 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 Optum within 15 days of receipt of the claim. If the Covered Person filed a pre-service claim improperly, Optum 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, Optum 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, Optum 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. Optum 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 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 Optum within 30 days of receipt of the claim, as long as all needed information was provided with the claim. Optum will notify the Covered Person within this 30-day period. If additional information is needed to process the claim; Optum may request a one-time extension not to be longer than 15 days and then hold the claim until all information is received.

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

A denial notice will be provided to the Covered Person to explain the reason for denial. It will 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 be notified of the benefit determination in writing or electronically within 72 hours after Optum 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 (3) days.

If the Covered Person files an urgent claim improperly, Optum 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, Optum will notify the Covered Person of the information 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 Optum's receipt of the requested information, or at the end of the 48-hour time period allotted/given, whichever is sooner/earlier.

A denial notice will be provided to the Covered Person to explain the reason for denial. It will 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 Optum's customer service department before requesting a formal appeal. If the Covered Person is not satisfied with a benefit determination he or she may appeal the decision, as described below. If the Covered Person initially contacted Optum's Customer Service Department and later want to request a formal appeal in writing, the Covered Person should again contact Optum 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.

Member Appeal Rights and Information

The following are FAQ's about Your Right to Request a Review of an Initial Non-Coverage / Adverse Determination / Denial:

Q. What if I need help understanding this notice?

A. Contact Optum Behavioral Solutions, if you need help understanding this notice or Optum's decision to deny you a service or coverage.
For a clinical review, your provider must contact the reviewer who made the determination to discuss the basis for the decision.

Q. How do I contact Optum?

A. You may contact Optum by telephone, mail or fax at:

Optum Behavioral Solutions Appeals Department
P.O. Box 411517
St. Louis, MO 63141-3517
Fax number: 1-866-209-9317
Phone: 1-866-859-0505

Q. What if I don't agree with this decision?

A. You have a right to request an appeal review of any decision not to provide you a benefit or pay for an item or service (in whole or in part).

Q. How do I request a review of the decision?

A. Contact Optum within 180 calendar days of your receipt of the notice of the non-coverage/adverse determination/denial.

Q. Who may request a review of the decision?

A. You, your provider, or someone you consent to act on your behalf (your authorized representative) may request a review. Contact Optum if you would like to name an authorized representative to request a review of the decision on your behalf.

Q. What information is needed to request a review of the decision?

A. Here is the required information needed to request a review of a decision;

- Your name and identification number.
- The dates of service that were denied.
- Your provider's name.
- Any information you would like to have considered, such as records related to the current conditions of treatment, co-existent conditions or any other relevant information.

Q. What if my situation is urgent?

A. If your situation meets the definition of urgent under the law, Optum will conduct an expedited review.

An urgent situation is one in which your health may be in serious jeopardy or, if in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision.

If you believe your situation is urgent, contact Optum immediately to request an urgent review.

Q. What happens next?

A. If you request an appeal review, it will be conducted by someone who was not involved in making the non-coverage determination/denial, and who is not a subordinate to the reviewer who made the determination.

For an urgent review, Optum shall make a determination and will notify you verbally and in writing within 72 hours of the receipt of your request.

For a non-urgent review of a denial of services that have not yet been provided to you, Optum will make a determination and will notify you in writing within 15 calendar days of the receipt of your request.

For a non-urgent review of a denial of services that have already been provided to you, Optum will make a determination and will notify you in writing within 30 calendar days of the receipt of your request.

Additional information about your appeal rights:

- If you are requesting an urgent review, you may also request that a separate urgent review be conducted at the same time by an independent third party.
- If Optum exceeds the time requirements for making a determination and providing notice of the decision, you may bypass the Optum internal review process and request a review by an independent third party, or avail yourself of any applicable remedy under federal or state law.
- If Optum continues to deny the payment, coverage, or service requested you may request an external review by an independent third party, which may review your case and make a final decision.

Q. Can I request a copy of the information used in making the non-coverage determination/denial?

A. Yes, you may request, at no cost, a paper copy of any relevant documents, records, guidelines, benefit provisions, or other information used to make a decision. Some information will be released only upon your written consent.

The clinical guidelines used by Optum are also available at:
www.providerexpress.com.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at **1-866-444-EBSA (3272)**, or visit their website at: **www.askebsa.dol.gov.**

For an urgent review, Optum will make a determination and will notify you verbally and in writing within 72 hours of the receipt of your request.

For a non-urgent review of a denial of services that have not yet been provided to you, Optum will make a determination and will notify you in writing within 15 calendar days of the receipt of your request.

For a non-urgent review of a denial of services that have already been provided to you, Optum will make a determination and will notify you in writing within 30 calendar days of the receipt of your request.

The following are FAQs about Your Right to Request a Review of a Final Internal Non-Coverage / Adverse Determination/Denial:

Q. What if I need help understanding this notice?

A. Contact Optum Behavioral Solutions if you need help understanding this notice or Optum's decision to deny you a service or coverage.

For a clinical analysis, your provider can contact the reviewer of the determination to discuss the basis for the decision.

Q. How do I contact Optum?

A. You may contact Optum by telephone, mail or fax at:

Optum Behavioral Solutions
Appeals Department
P.O. Box 411517
St. Louis, MO 63141-3517
Fax number: 1-866-209-9317
Phone: 1-866-859-0505

Q. What if I don't agree with this decision?

A. You have a right to request an external review by an Independent Review Organization (IRO) of a decision not to provide you a benefit or pay for an item or service (in whole or in part).

Optum is required by law to accept the determination of the IRO.

Q. How do I request an independent external review of the decision?

A. Contact Optum in writing within 180 calendar days of your receipt of the notice of the final internal non-coverage/adverse determination/denial.

Q. Will I have to pay the cost of the independent external review?

A. No, there is no cost to you for an independent external review.

Q. What information is needed to request an independent external review of the decision?

A. You will need the following information:

- Your name and identification number.
- The dates of service that were denied.
- Your provider's name.
- Any information you would like to have considered, such as records related to the current conditions of treatment, co-existent conditions or any other relevant information.

Q. Who may request an independent external review of the decision?

A. You, your provider or someone you consent to act for you (your authorized representative) may request a review.

Contact Optum if you would like to name an authorized representative to request a review of the decision on your behalf.

Q. What if my situation is urgent?

A. If your situation meets the definition of urgent under the law, you may request an expedited review.

An urgent situation is one in which your health may be in serious jeopardy or, if in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision.

If you believe your situation is critical, contact Optum immediately to request an urgent review.

Q. Is an independent external appeal review available for any adverse decision by Optum?

A. No, an independent external review will not be available if the service was not covered under your plan, if you were not eligible under your plan, if you did not exhaust any required internal review processes, or if you do not provide the information necessary to conduct a review.

Q. What happens next?

A. If you request an independent external review, Optum will complete a preliminary review, immediately for an urgent request, or within five (5) business days for a non-urgent request, to determine if your request is complete and is eligible for an independent external review.

If your request is not complete, Optum will provide you written notice of the additional information that is needed.

If your request is not eligible, Optum will provide you written notice to explain the reason(s).

If your request is eligible and complete, an Independent Review Organization (IRO) will be selected for the review, and Optum will provide you written notice.

Q. How will the Independent Review Organization obtain information to review my case?

A. Optum will send all relevant information that was used to make the non-coverage/adverse decision to the IRO within 24 hours for an urgent review, or within five (5) working days for a non-urgent review.

For a non-urgent review, you will have ten business days from your request to submit pertinent information to the IRO for review.

Q. When will the Independent Review Organization make a determination and notify me?

A. For an urgent review, the IRO will make a determination and will notify you within 72 hours, and will provide you a written notice of the decision. For a non-urgent review, the IRO will make a determination within 45 calendar days and will provide you a written notice of the decision.

Q. Can I request a copy of the information used in making the non-coverage/adverse determination/denial?

A. Yes, you may request, free of charge, a paper copy of any relevant documents, records, guidelines, benefit provisions, or other information used to make a decision. Some information will be released only upon your written consent.

The clinical guidelines used by Optum are also available at: **www.providerexpress.com.**

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at **1-866-444-EBSA (3272)**, or visit their website at: **www.askebsa.dol.gov.**

When all applicable appeal options have been exhausted, you may have the right to file a civil action under section 502(a) of the Employee Retirement and Income Security Act (ERISA), or any applicable federal or state law.

Additional Rights

You may request a paper copy of any relevant documents, records, guidelines or other information Optum used in making it determination at no charge. To request a copy of this information, please contact Optum at the address or telephone number on page 1 of this document. Some information will require a written request or consent from the member before it can be released.

Legal Actions

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

Incontestability of Coverage

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

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

Information and Records

At times, additional information may be required. The Covered Person must agree to furnish Optum Behavioral Solutions with all information and proofs that is reasonably required regarding any matters pertaining to the Policy. If the Covered Person does not provide this information when requested, Optum 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 Optum with all information or copies of records relating to the services provided to you. The State of Ohio has the right to request this information at any reasonable time. This applies to all Covered Persons, including Dependents, whether or not they have signed the Employee enrollment form. Optum agree that such information and records will be considered confidential.

Optum has 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 Optum is required to do by law or regulation. During and after the term of the Policy, Optum and their 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, it is recommended 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 Optum, also Optum may charge you a reasonable fee to cover costs for completing the forms or providing the records.

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

Overview of Coordination of Benefits (COB)

What this section includes:

- How your Benefits are coordinated with other medical plans, under the State of Ohio's Plan;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event that the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you, if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan;
- A medical component of a group long-term care plan, such as skilled nursing care;
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- Medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The primary plan will pay benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Remember to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Contact Optum at 1-800-852-1091 to update your COB information. You will need to provide the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules outlined below, in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as a Participant pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your Dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan

that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:

- The parents are married or living together whether or not they have ever been married and not legally separated; or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse of the parent with custody of the child; then
  - the parent not having custody of the child; then
  - the Spouse of the parent not having custody of the child.

- Plans for active Participants pay before plans covering laid-off or retired participants.
- The Plan that has covered the individual claimant the longest will pay first; the expenses must be covered in part under at least one of the plans; and
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan

Example #1

1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are no well and decide to see a Physician. Since you are a Covered Person under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

Example #2

2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent Child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When the Plan is Secondary

If the Plan is secondary, the amount it will pay for a Covered Health service is determined by the following steps below:

- The Plan determines the amount it would have paid had it been the only plan involved.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining which Plan is Primary - To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you do not elect it. However, there are Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- Individuals with end-stage renal disease, for a limited period of time.

Your current Plan coverage is primary and Medicare is almost always secondary (and is only primary in a few instances).

Determining the Allowable Expense when this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The State of Ohio may obtain the facts needed from, or provide them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The State of Ohio does not need to advise, or obtain the consent of, any person to do this. Each person claiming benefits under this Plan must provide Optum Behavioral Solutions any facts needed to apply those rules and determine benefits payable. If you do not provide Optum Behavioral Solutions the information necessary to apply these rules and determine the Benefits payable, your claim will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that Optum Behavioral Solutions should have paid. If this occurs, the amount owed may be paid to the other plan.

If the Plan pays you more than it owes under the COB provision, the excess should be paid back promptly. Otherwise, the State of Ohio may recover the amount in the form of salary, wages, or benefits payable under any State of Ohio-sponsored benefit plans, including this Plan. The State of Ohio also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, Optum Behavioral Solutions reserves the right to recover the excess amount, by legal action, if necessary.

Refund of Overpayments

If the State of Ohio pays for Benefits for expenses incurred on behalf of a Covered Person, that Covered Person, or any other person or organization that was paid must provide a refund to the State of Ohio 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 State of Ohio made exceeded the Benefits under the Plan; or
- All or some of the payment was made in error.

The refund should equal the amount the State of Ohio paid in excess of the amount that should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the State of Ohio secure 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 State of Ohio may reduce the amount of any future

Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. The State of Ohio may have other rights, in addition to the right to reduce future Benefits

Subrogation and Reimbursement

Your Benefits may be impacted if you suffer from a Sickness or Injury caused by a third party. The Plan has a right to subrogation and reimbursement as defined below.

Right of Recovery

The Plan has the right to recover benefits paid on you or your Dependent's behalf that were:

- Made in error;
- Due to a mistake in fact;
- Advanced during the time period of meeting the plan year Annual Deductible; or
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the plan year.

Benefits paid due to misrepresentation of facts by you or your Dependent are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested; or
- Reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of the Annual Deductible and/or meeting the Out-of-Pocket Maximum for the plan year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation

The right to subrogation means the Plan is substituted to, and shall succeed to, any and all legal claims that you may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a Sickness or Injury for which a third party is considered responsible (e.g. an insurance carrier if you are involved in an auto accident).

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party. You must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- Any insurer or other indemnifier of any person or entity who caused the Sickness, Injury or damages;
- State of Ohio in workers' compensation cases; or
- Any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers' compensation coverage; or
  - any other insurance carrier or third-party administrator (TPA).

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party;
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. So-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right;
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or

after any determination of liability) or judgment, regardless of how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights;

- Benefits paid by the Plan may also be considered to be Benefits advanced; and you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - complying with the terms of this section;
  - providing any relevant information requested;
  - signing and/or delivering documents at its request;
  - notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - responding to requests for information about any accident or injuries;
  - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
  - obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.
- If you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- You may not accept any settlement that does not fully reimburse the Plan without its written approval.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- The Plan's rights will not be reduced due to your own negligence.
  - the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
  - the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- in case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- as such, the plan has the right to terminate your benefits, deny future Benefits or take legal action against you. Additionally, the value of Benefits paid by the plan relating to any Sickness or Injury caused by a third party and not recovered by the Plan due to lack of cooperation from you or your representative will off-set any future Benefits.
- if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Subrogation Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

Termination of Coverage

Employee Coverage

Employee coverage ends on the earliest of the following:

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

Disability

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

Coverage ends on the month in which the Employee was terminated.

Leave of Absence or Temporary Layoff

The Employer has the right to continue the person's employment and coverage under this Plan during a period in which the person is away from work due to an approved leave of

absence or temporary layoff. The period of continuation is determined by the Employer based on the Employer's general practice for an Employee in the person's job class.

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

Dependent Coverage

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

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

Coverage for an individual Dependent ends on the earlier of:

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

Continuation of Coverage for Incapacitated Children

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

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

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

CONTACT INFORMATION:

Optum Behavioral Solutions
P. O. Box 411517
St. Louis, MO 63141-3517
1-800-852-1091

Glossary of Terms

Allowable Expense (Amount)

This is a health care expense that is covered, at least in part, by the Plan providing coverage to the Employee, Spouse or Dependent Child.

Behavioral Health Services

Services and supplies which are:

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

Benefit Year/Plan Year

This is the 12-month period from July 1 through June 30 during for which services are rendered, and your deductible and co-insurance are accumulated.

Coordination of Benefits (COB)

Coordination of benefits applies if you are covered by more than one health benefits plan.

Co-insurance

The percentage of eligible expenses that the health care plan pays after the annual deductible is met. For example, an 80 percent co-insurance rate means you pay 20 percent and the Plan pays 80 percent.

Co-payment

A specified dollar amount you pay to a health care provider for eligible expenses such as office visits. Copays do not count toward your annual deductible.

Covered Expenses

The actual cost to the Covered Person of the Reasonable Charge for Behavioral Health Services received from a provider.

Covered Person

The Employee and the Employee's spouse and/or Dependent Children are covered under this Plan.

Course of Treatment

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

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

Covered Services

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

Deductibles

The amount you pay for eligible expenses each plan year before the plan begins to pay any benefits.

Emergency Care

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

Employee

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

Facility Services

These are services provided during a hospitalization, partial hospitalization, residential stay, or day or structured outpatient facility treatment).

Fiscal Year

This is a period of one year beginning with July 1 and ending on June 30 of the following year.

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 specializing in MHSA treatment and is 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 Federal Social Security Act.

MHSA Treatment

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

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

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

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

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

Prescription Drugs are not considered Mental Disorder Treatment.

Network Provider

A Provider that is participating in the Optum Behavioral Solutions network.

Out-of-Network (OON) Provider

A Provider that ***is not*** participating in the Optum Behavioral Solutions network.

Out-of-Pocket (OOP) Maximum

The cap or maximum amount you pay for eligible out-of-pocket health care expenses during the Plan year. After the out-of-pocket expenses reach the maximum, the Plan pays 100 percent of additional eligible expense for the remainder of the Plan year.

A legally qualified:

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

Plan

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

Provider

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

Psychologist

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

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

Reasonable and Customary Charge (R & C)

These are charges for services rendered by or on behalf of a Network Physician, an amount not to exceed the amount determined by the third-party administrator (TPA) in accordance with the applicable fee schedule.

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

- The complexity of the service
- The range of services provided

The prevailing charge level in the geographic area where the Provider is located and other geographic areas having similar medical cost experience.

Total Disability or Totally Disabled

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

Treatment Center

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

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

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

Utilization Review

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