Sutter Health Partners
With You. For Life.

Group Mental Health Benefits Program: Value Choice

For Employees Of

Marin General Hospital

Summary Plan Description

Effective January 1, 2006

Este folleto contiene un resume en ingles de sus derechos del Plan y beneficios bajo el Marin General Hospital de Beneficios del Empleado. Si usted tiene dificultad para entender cualquier parte de este folleto, contacte BRMS, PO Box 2650, Rancho Cordova, CA 95741, 1-888-326-2555.

INTRODUCTION

This summary plan description (SPD) provides a brief description of the Group Mental Health Benefits Program Value Choice portion of the Marin General Hospital Employee Group Health Plan (Plan) sponsored by Marin General Hospital (Employer) that is administered by Sutter Health Partners. The benefits described in this SPD have been designed to pay a large portion of the usual, customary and reasonable fees for a broad range of necessary medical services, treatments, and supplies and will give you substantial protection against the cost of serious sickness and injuries.

Please read this SPD thoroughly and become familiar with its provisions. After you have read this SPD, keep it with your other valuable papers for future reference.

Note that this SPD is just a summary and general description of this portion of the Plan – it does not fully describe or summarize the provisions and operation of all of the benefits that may be provided through the Plan. The Employer has a copy of the official plan document for the Plan, as it may be modified from time to time, that is readily available for your inspection. If you have questions or need a copy of the Plan, please contact the Plan Administrator.

If there is ever any conflict between the plan document and any statements made in this SPD, the plan document will control. If there is ever any conflict between either an insurance policy providing benefits under the Plan or any contracts for medical and prescription drug review services and either the plan document or this SPD, the insurance policy or contract will control. Please remember that no employee of the Employer – not even your supervisor – has any authority to bind the Employer to any benefit or procedure that conflicts with the official plan document, this SPD, or any such insurance policy or contract.

Although the Employer currently intends to continue all of the benefits described in this SPD, the Employer has reserved the right to amend, reduce or terminate any of these benefits at any time and for any reason. If any of the benefits provided under the Plan is amended or terminated, you may not receive benefits as described in other sections of this SPD. Although you may become entitled to receive different benefits, or benefits under different conditions, it is also possible that you will lose all benefits coverage. Loss of coverage may happen at any time, even after you retire, if the Employer decides to terminate a benefit under the Plan or your coverage under the Plan. In no event will you become entitled to any vested rights under any of the benefits provided under the Plan.

There are terms in this SPD that have a special meaning under the Plan and are listed in the "Definitions" section of this SPD. When reading the provisions of this SPD, it may be helpful to refer to this section. Becoming familiar with the terms defined in this section will give you a better understanding of the procedures and benefits described.

DEFINITIONS

Behavioral Health Services
Services and supplies that are:

- Covered Services for Mental Health and/or Substance Abuse Treatment;
- Given while the Covered Person is covered under the Plan; and
- Given by one of the following providers:
  - Physician
  - Psychologist
  - Licensed Counselor
  - Provider
  - Hospital
  - Treatment Center
  - Social Worker

- Behavioral Health Services include but are not limited to the following:
  - Assessment
  - Diagnosis
  - Treatment Planning
  - Medication Management
  - Individual, family and group psychotherapy
  - Psychological testing

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

Covered Person
You and your wife or husband or eligible domestic partner and/or dependent child(ren) who are covered under this Plan.

The employees and dependents who are eligible for the behavioral health benefits are the eligible employees and dependents of the Employer participating in the Value Choice Program portion of the Marin General Hospital Employee Group Health Plan. Please refer to the specific SPD for that portion of the Plan for detailed information on eligibility, effective dates, termination of coverage and other information.

Covered Services
Those services and supplies provided for the purpose of preventing, diagnosing or treating a behavioral disorder, psychological injury or substance abuse addiction and which are described in the section titled "What This Plan Pays" and not excluded under the section titled "Not Covered-Exclusions." Services and supplies will not automatically be considered Covered Services because there were prescribed by a Provider.

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.

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

Employee
A person on the payroll and regularly employed on a full-time basis of not less than 20 hours per week.

Hospital
An institution engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and that fully meets one of the following three tests:
1. It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations.
2. It is approved by Medicare as a Hospital.
3. It meets all of the following tests:
    a. It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick an injured persons by or under the supervision of a staff of duly qualified Physicians;
    b. It continuously provides on the premises 24 hour-a-day nursing service by or under the supervision of registered graduate nurses; and
    c. It is operated continuously with organized facilities for operative surgery on the premises.

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

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 that does participate in the UBH network.

Non-Network Provider
A provider that does not participate in the UBH network.

Physician
A legally qualified:
- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)

Plan
The employee welfare benefit plan established by the Employer that provides the benefits described in this SPD.

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; or
- A member or fellow of the American Psychological Association, if there is not government licensure or certification required.

Reasonable Charge For Behavioral Health Services
As to charges for services rendered by or on behalf of a Non-Network Provider, an amount measured and determined by UBH by comparing the actual charge for the service or supply with the prevailing charges made for it. The prevailing charge is determined by taking all the following into account:
- The complexity of the service;
- The range of services provided; and
- The prevailing charge level in the geographic area where the Provider is located and other geographic areas having similar medical cost experience.

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

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

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

Treatment Center
A facility that provides a program of effective MHSA 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 Employer.
- It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and board (if this Plan provides inpatient benefits at a Treatment Center);
  - Evaluation and diagnosis;
  - Counseling; and
  - Referral and orientation to specialized community resources.

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

UBH
United Behavioral Health.

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

Behavioral Health Benefits

Who Is Administering Your Behavioral Health Benefits?

UBH is administering your mental health and substance abuse benefits.

What Does This Plan Pay For?

Your benefit pays for Covered Expenses incurred for Behavioral Health Services that you or eligible family members might use from a Sutter Health Facility or a UBH Network Provider. Non-Network Providers are not covered except when services are emergent.

Schedule Of Benefits

THIS BENEFIT IS ADMINISTERED THROUGH UNITED BEHAVIORAL HEALTH **PLEASE CALL 1-866-374-6060**	
BENEFIT TYPE	**UBH PROVIDERS**
DETOXIFICATION (Two episodes per lifetime)	No Copay
MENTAL HEALTH & CHEMICAL DEPENDENCY COMBINED BENEFIT (Excludes medically necessary detoxification and substance abuse treatment – see below)	
❖ Inpatient (facility and professional) 30 days per calendar year	No Copay
❖ Outpatient (20 visits per calendar year)	$ 5 Copay

Mental Health

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

What This Plan Pays

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

You or eligible family members must make copayment and coinsurance payments. Behavioral health benefit will be paid according to the Schedule Of Benefits above.

Remember, the date when you receive the Behavioral Health Service is the day the Covered Expense is incurred. Covered Expenses are the actual cost charged for Behavioral Health Services. UBH calculates charges following evaluation and validation of all provider billings in accordance with the methodologies:

- In the most recent edition of the current procedural terminology or DSM code;
- As reported by recognized professionals or publications.

HOW TO USE YOUR BENEFITS

When you are ready to access your benefits, call UBH's toll-free number **1-866-374-6060**, which is available 24 hours-a-day, 7 days-a-week. A UBH clinician will answer your call and begin the Utilization Review process. Through Utilization Review, UBH assesses your issue or problem, then makes sure you receive the level of care you need to address your symptom(s) and the level of seriousness. To assess your symptom(s), UBH uses a set of industry-approved and clinically based guidelines. After UBH assesses your personal situation, you will be referred to a Network Provider who is experienced in addressing your specific issues.

The care you receive through your behavioral health benefit is confidential. UBH shall not disclose confidential information to anyone without your consent, except where required by federal and State laws.

Remember, call UBH before you visit a Network Provider. If you do not get a UBH approval beforehand, your services will not be covered, except when services are emergent.

Emergency Care

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

Remember, once Emergency Care is ended, call UBH to get a referral to receive any additional services covered at the Network level. Without a required referral, benefits for any additional services will not be covered.

What If You Are Unsatisfied With Your Current Network Provider?

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

Copayments And Coinsurance

You must satisfy any applicable copayments and/or coinsurances before behavioral health benefits are payable.

A copayment/coinsurance is the amount you must pay to your Network Provider when services are given.

See the Schedule Of Benefits above for each copayment and coinsurance amount. Remember, you must make a copayment and/or coinsurance each time you use your benefits. For example, one copayment on a Network Provider visit does not satisfy the copayments for following visits.

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

MAXIMUM BENEFIT
In the SPD for the Value Choice Program portion of the Plan, you will find the maximum benefit payable for you and your eligible family member(s). This maximum applies to you and each Covered Person for their lifetime.

NOT COVERED - EXCLUSIONS
The following exclusions apply regardless of whether the services, supplies, or treatment described in this section are recommended or prescribed by your provider and/or the only available treatment options for your condition.

The behavioral health benefit 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 the SPD for the Value Choice Prescription Drug Program portion of the Plan to determine whether prescription drugs are a covered benefit.
- Services or supplies for MHSA Treatment that, in the reasonable judgment of UBH, are any of the following:
  - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
  - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
  - not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;
  - typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or
  - not consistent with UBH's Level of Care Guidelines or best practice 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 of services, except for the initial diagnoses, for a primary diagnoses of Mental Retardation (317, 318, 319), Learning, Motor Skills, and Communication Disorders (315), Pervasive Developmental Disorder (299), Conduct Disorder (312), Dementia (290, 294), Sexual, Paraphilia, and Gender Identity Disorders (302), and Personality Disorders (301), as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by UBH.

- Unproven, Investigational or Experimental Services. Services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a Covered Service if the service, treatment, or device is considered to be unproven, investigational, or experimental.
- Custodial Care except for the acute stabilization and return back to your baseline level 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 competent functioning in activities of daily living; or
  - it is not expected that the care provided or psychiatric treatment alone will reduce this disorder, injury or impairment to the extent necessary to function outside a structured environment. This applies when there is little expectation of improvement in spite of any all treatment attempts.

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 National Institutes of Health.

- Nutritional Counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.

- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.

- Services or treatment rendered by unlicensed providers, including pastoral counselors (except as required by law), or which are outside the scope of the providers' licensure.

- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.

- Light boxes and other equipment including durable medical equipment, whether associated with a behavioral or non-behavioral condition.

- Private duty nursing services while confined in a facility.

- Surgical procedures including but not limited to sex transformation operations.

- Smoking cessation related services and supplies.

- Travel or transportation expenses unless UBH has requested and arranged for you to be transferred by ambulance from one facility to another.

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

- Services performed by a provider with the same legal residence as you.

- Behavioral Health Services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.

- Charges in excess of any specified Plan limitations.

- Any charges for missed appointments.

- Any charges for record processing except as required by law.

- Services provided under another plan. Service or treatment for which other coverage is required by federal, State or local law to be purchased or provided through other arrangements. This includes but is not limited to coverage required by workers' compensation, no-fault auto, or similar legislation. If coverage under workers' compensation or a similar law is optional for you because you could elect it or could have it elected for you, benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected.

- Behavioral Health Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country when you are legally entitled to other coverage.

- Treatment or services received prior to you being eligible for coverage under the Plan or after the date your coverage under the Plan ends.

NETWORK PROVIDER CHARGES NOT COVERED

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

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

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

CLAIMS INFORMATION

Why Would You Want To File A Claim?
You do not need to file claims for Network Provider services. Network Providers will automatically file claims with UBH. However, you may need to file a claim for Non-Network Provider services. Instructions for filing a claim are outlined below.

How To File A Claim
- Obtain a claim form from UBH by calling 866-374-6060.
- Complete the form making sure to include:
    - Your name and member ID number
    - Your employer's name
    - The patient's (yours or the eligible family member's) name
    - The diagnosis
    - The date the service(s) or supply(ies) were incurred
    - The specific service (s) or supply(ies) provided.

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

How And When Claims Are Paid
You will be paid for all expenses when UBH receives satisfactory proof of loss, except in the following cases:
- If a court has ordered your dependent to undergo medical or psychological evaluation or treatment, UBH will pay the Provider directly.
- If you request in writing, when you complete the claim form, that the payments be made directly to a Provider.

Once UBH makes these payments, it satisfies the Plan's obligation for those benefits.

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

Any benefits continued for your dependents after your death will be paid to one of the following:
- Your surviving spouse;

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

Benefit Determinations

Pre-Service Claims
Pre-service claims are those claims that require notification or approval prior to receiving Behavioral Health Services. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from UBH within 15 days of receipt of the claim. If you filed a pre-service claim improperly, UBH will notify you of the improper filing and how to correct it within five days after the pre-service claim was received. If additional information is needed to process the pre-service claim, UBH will notify you of the information needed within 15 days after the claim was received, and may request a one-time extension not longer then 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received 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, your request will be decided upon within 24 hours, provided the request is made at least 24 hours prior to the end of the approved treatment. UBH will make a determination on the request for the extended treatment within 24 hours from receipt of the request. If the request for the extended treatment is not made a least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent claim and decided according to the time frames described below.

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

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

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, UBH will

notify you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, 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 MHSA Treatment. In these situations:

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

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

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

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

UBH's receipt of the requested information; or

The end of the 48-hour period which you were given to provide the additional information, if the information is not received within that time.

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

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

How To Appeal A Claim Decision

If you disagree with a claim determination after following the above steps, you 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.

Your first level appeal request must be submitted to UBH within 180 days after you receive a claim denial at the following address:

Behavioral Health
Appeals & Complaint Unit
P.O. Box 32040
Oakland, CA 94604
Fax: (415) 547-6259

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. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to the copies of all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations
First Level Pre-Service And Post-Service Claim Appeals
You 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 you 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 you 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 the "Urgent Claim Appeals That Require Immediate Action" section below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. See the "Second Level Pre-Service And Post-Service Claim Appeals" section below.

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

Second Level Pre-Service And Post-Service Claim Appeals
If you are not satisfied with the first level appeal decision, you have 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 or pre-service claims, the second level appeal will be conducted and you 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 you will notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

We have delegated to UBH the discretionary authority to interpret and administer the provisions of the Plan. UBH's appeal decision is final and binding.

Urgent Claim Appeals That Require Immediate Action
An appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function. In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call UBH as soon as possible.

UBH will provide you 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 your condition.

Right To Exchange Information For Coordination Of Benefits.
UBH requires certain information to coordinate benefit payments and UBH may have to get the facts from or give them to another organization or person. UBH need not tell, or get the consent of, any person to do this.

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

ERISA INFORMATION
For more information about the mental health benefits portion of the Plan, see the SPD for the Value Choice Program portion of the Plan. That same information applies to this portion of the Plan except as set forth below.

The third parties who are providing services under this portion of the Plan are:

- Enrollment/Eligibility Management:
  BRMS
  PO Box 2650
  Rancho Cordova, CA 95741
  Telephone: 888-326-2555
- Benefit Manager:
  United Behavioral Health
  P.O. Box 32040
  Oakland, CA 94604
  Telephone: 1-866-374-6060
  www.unitedbehavioralhealth.com
- Program Manager
  Sutter Health Partners
  4000 Civic Center Drive, Suite 110
  San Rafael, CA 94903
  Telephone: 866-307-6600
  www.sutterhealthpartners.com