

WAKE FOREST UNIVERSITY

SUMMARY PLAN DESCRIPTION
For
BEHAVIORAL HEALTH SERVICES

July 1, 2017-June 30, 2018
Revised November 20, 2017

TABLE OF CONTENTS

WHO IS WAKE FOREST UNIVERSITY?	Page 3
ENROLLEE RIGHTS AND RESPONSIBILITIES	Page 4
SECTION ONE	
Who Is Covered?	Page 6
SECTION TWO	
How The Plan Works	Page 10
SECTION THREE	
Behavioral Health Care	Page 14
SECTION FOUR	
Exclusions	Page 17
SECTION FIVE	
Coordination of Benefits	Page 21
SECTION SIX	
Protected Health Information	Page 24
SECTION SEVEN	
Termination of Member Coverage	Page 25
SECTION EIGHT	
Continuation of Coverage	Page 26
SECTION NINE	
Utilization Review	Page 29
SECTION TEN	
Grievances and Appeals	Page 34
SECTION ELEVEN	
ERISA Rights	Page 42
SECTION TWELVE	
General Provisions	Page 44
SECTION THIRTEEN	
Definitions	Page 48
ADDENDUM	
Summary of Benefits	Page 52

WHO IS WAKE FOREST UNIVERSITY?

This document describes the behavioral health benefits portion of the Wake Forest University employee Health Plan (the “Plan”).

Wake Forest University is the Plan sponsor for this Summary Plan Description for Behavioral Health Care Services and is subject to the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Plan Insurance Portability and Accountability Act of 1996 (HIPAA). This Summary Plan Description describes your covered Behavioral Health Benefits, conditions, limits and exclusions from coverage. This Summary Plan Description and the Summary of Benefits also describe Coinsurance, Co-payments, Deductibles and other Out-of-Pocket expenses. You should read the Summary of Benefits since we will refer to it in this Summary Plan Description.

Wake Forest University decides your eligibility for Covered Behavioral Health Benefits and is paying part of the cost of this coverage. Wake Forest University Human Resources will give its eligibility rules at the time of enrollment.

Upon request, you will be provided with the following:

- ♦ The Summary Plan Description for Behavioral Health Care Services and a Summary of Benefits;
- ♦ Explanation of Utilization Review criteria and treatment protocol for specific conditions;
- ♦ Reasons for denying a requested treatment, including the reasons for the denial and an explanation of the Utilization Review criteria or treatment protocol on which the denial is based; and
- ♦ Medically and psychologically based criteria for determining whether a specified procedure, test or treatment is experimental.

Wake Forest University is referred to as “Wake Forest University” “we,” “us,” or “our.” The words “Enrollee,” “you,” “your,” and “yours” refer to you, the person to whom this Enrollee Coverage Summary Plan Description for Behavioral Health Care Services is issued and who is properly enrolled in the Plan. It also refers to the Enrollee’s covered spouse and covered Dependents, collectively the Enrollees. Wake Forest University has the right to delegate another entity to administer their behavioral health Benefits.

The capitalized words or terms used in this Summary Plan Description that are not otherwise defined have the meanings set forth in section Twelve, “Definitions.”

Please keep this Summary Plan Description and the Summary of Benefits in a safe place for future use.

PLEASE CALL CAROLINA BEHAVIORAL HEALTH ALLIANCE (CBHA) THE BEHAVIORAL HEALTH PLAN ADMINISTRATOR DURING BUSINESS HOURS AT 1-800-475-7900 IF YOU HAVE QUESTIONS ABOUT YOUR BENEFITS, PAYMENTS, OR COST SHARING.

Members Rights and Responsibilities

Enrollee Rights

Enrollees whose behavioral health Benefits are managed by Carolina Behavioral Health Alliance (CBHA), have the right to:

Be treated with courtesy, respect and dignity without regard to race, gender, cultural background, religion or other protected classifications.

A clear and understandable explanation of benefit Plans and how to access behavioral health services.

Request and receive information about CBHA and its services.

Request and receive information about how CBHA determines medical necessity and authorizes behavioral health services.

Request access to inspect and copy their protected health information and to request that health information be amended if they have reason to believe it is inaccurate or incomplete.

Request that CBHA communicate with them through alternate means or locations if use of the standard communications process would endanger an Enrollee or others.

Privacy and confidentiality regarding their clinical information, including their diagnoses; information shall be kept in strict confidence and shall not be shared with anyone without the Enrollee's written permission, except as permitted or required by law.

Request restrictions on uses and disclosures of protected health information.

Access to services and CBHA Providers within timeframes that meet the needs of the current situation, including immediate access in case of emergency.

Be informed about CBHA Providers, including location, office hours and specialties.

Participate with practitioners in decision-making regarding treatment Planning, including a clear explanation of diagnoses and treatment options, and, in cases where medication is prescribed, a clear explanation of the medication(s), including any possible side effects.

Be informed of all facts about any charges and bills received, regardless of who is responsible for payment.

File a complaint or Grievance and to Appeal any denial of services in accordance with CBHA policies and applicable law. Enrollees shall be provided with information about how to file a complaint, Grievance or Appeal.

Receive a copy of their rights and responsibilities.

Enrollee Responsibilities

Enrollees whose behavioral health benefits are managed by Carolina Behavioral Health Alliance (CBHA), have the responsibility to:

Read and adhere to the guidelines of the Health Plan as they appear in the Summary Plan Description of Coverage.

Present their BCBSNC ID card before receiving each service and to protect their BCBSNC ID card from unauthorized use.

Call CBHA when you have a question or if the material given to you by CBHA is not clear.

Provide CBHA and its Providers accurate and relevant information regarding current and past health condition(s) to ensure appropriate care and treatment; this includes granting a release of information and helping to obtain medical records from former Providers of care, if applicable.

Actively participate with Providers in the development of treatment Plans, to cooperate with agreed upon treatment goals, instructions and guidelines and to discuss progress or lack of progress with their Providers.

Inform their Providers of care of any changes in their health care Benefits.

Report concerns about fraud, abuse or quality of care.

Make and keep appointments for non-emergency behavioral care, to adhere to the treatment Plan and to take medications as prescribed. If it is necessary to cancel an appointment, Enrollees have a responsibility to give the Provider's office adequate notice.

Inform Providers of any changes in medication prescribed by other practitioners.

Notify their Group administrator and CBHA if they have any additional coverage; notify the Group administrator of any changes regarding Dependents and marital status as soon as possible. Be considerate and courteous to CBHA Providers, their staff and CBHA representatives.

If you have any questions, please feel free to call CBHA at 1-800-475-7900 or write to us at: P.O. Box 571137, Winston-Salem, NC 27157-1137.

SECTION ONE: WHO IS COVERED?

PLEASE NOTE: For purposes of this Section, "you" means the Enrollee covered under this Summary Plan Description.

1. Who is Eligible?

- A. Employees and Retirees: To be covered under the *Plan*, you must qualify in one of the classes listed below. However, your *employer* may establish additional criteria you must meet before you are eligible for coverage. This may include satisfying a probationary period before your coverage begins.

- Class 1 - Full time, regular faculty (budgeted to work between 1096-1462 hours per year)
- Class 2 - Effective 7/1/13: Full time, regular staff and administrators (budgeted to work between 1560 and 2800 hours per year). Covered by the plan prior to 7/1/13: Full-time, regular staff and administrators (budgeted to work between 1400 and 2080 hours per year).
- Class 3 - Regular part time faculty (budgeted to work at least 1000 hours per year, but less than 1096 hours per year)
- Class 4 - Effective 7/1/13: Regular part time staff and administrators (budgeted to work 1000 hours per year, but less than 1560 hours per year). Covered by the plan prior to 7/1/13: Regular part-time staff and administrators (budgeted to work at least 1000 hours per year, but less than 1400 hours per year).
- Class 5 - Effective 7/1/13: Reynolda House full-time staff (budgeted to work between 1560 and 1820 hours per year). Covered by the plan prior to 7/1/13: Reynolda House full-time staff (budgeted to work between 1400 and 1820 hours per year).
- Class 6 - Effective 7/1/13: Reynolda House part-time staff (budgeted to work at least 1000 hours per year, but less than 1560 hours per year). Covered by the plan prior to 7/1/13 Reynolda House part-time staff (budgeted to work at least 1000 hours a year, but less than 1400 hours per year).
- Class 7 - Retirees as defined in the policy of Wake Forest University. Retirees are defined as: faculty and staff that have retired from the university. Retirees must have university medical benefits upon retirement and between the ages of 62 and 65 at the point of retirement. Retirees over 65 are not eligible for the *Plan*.
- Class 8 - Retirees are defined as: faculty and staff that have retired from the university. Retirees must have university medical benefits upon retirement and between the ages of 62 and 65 at the point of retirement. Spouses of retirees do not need to be age 62-65. As long as the retired employee was age 62 at retirement, the spouse can be on the plan. Retirees over 65 are not eligible for the *Plan*.
- Class 9 - Phased retirement program *employees*.
- Class 10 - Disabled *employees* that are eligible for retirement at point of disability and are between the ages of 62 and 65 at the point of retirement. Retirees over 65 are not eligible for the *Plan*.

You may also be eligible for coverage under the *Plan* if the *Plan Administrator* allows eligibility to extend to other persons, such as retirees. Employees who retire with at least 10 years of service and are at least 62 years of age are eligible to remain on this plan. Those that retire after age 65 are not eligible for this plan but may be eligible for other retiree benefits offered by Wake Forest University.

- B. Dependent Eligibility: For *dependents* to be covered under the *Plan*, you must be covered and your *dependent* must be one of the following:
- Your spouse, under an existing marriage that is legally recognized under any state law.
 - Your, or your spouse's *dependent children through the end of the month of* their 26th birthday. Your *employer* may require proof that your *dependent child* meets the definition of *dependent child* as outlined in the "Definitions."
 - A *dependent child* with a mental or physical disability and incapable of self-support may continue to be covered under the *Plan* regardless of age if the condition exists and coverage is in effect when the child reaches the age of 26. The disability must be medically certified by the child's *doctor* and may be verified annually by the *Plan*.

NOTE: Every eligible employee may enroll eligible *dependents*. However, if both the husband and wife are *employees*, they may choose to have one covered as the *employee*, and the spouse covered as the *dependent* of the *employee*; **or**, they may choose to have both covered as *employees*. Eligible children may be enrolled as *dependents* of one spouse, but **not** both.

Family Dependents are eligible for coverage on the same date the Employee becomes eligible. If an Employee elects Dependent coverage, the following members of his or her family may have coverage:

Adoptive children shall be treated the same as newborn infants. They are eligible for coverage on the same basis as newborns upon placement in the adoptive home, regardless of whether a final decree of adoption has been entered; provided that a petition for adoption has been duly filed and is pursued to a final decree of adoption.

Foster children shall be treated the same as newborn infants. They are eligible for coverage on the same basis upon placement in the foster home.

- C. Qualified Medical Child Support Order. The Federal Omnibus Budget Reconciliation Act of 1993 requires that any child of an Enrollee who is an alternate recipient under a qualified medical child support order shall have a right to Dependent coverage under this Summary Plan Description. A qualified medical child support order (QMCSO) is any judgment, decree or order that is issued by an appropriate court or through an administrative process under state law that: 1) provides for coverage of the child of an Enrollee under the Plan; 2) is either issued according to state law or a law relating to medical child support described in Section 1908 of the Social Security Act. A QMCSO must be specific as to the Plan, the participant whose child(ren) is (are) to be covered, the type of coverage, the child(ren) to be covered and the length of coverage. A copy of the QMCSO procedures for the Plan may be obtained free of charge from the Plan Administrator.

2. **Enrollment Requirements**. In order to obtain coverage, the Employee must complete and submit an Enrollment Application form to Wake Forest University within the required time periods discussed below.

3. **Application for Enrollment on or Prior to Effective Date of Contract.** Persons who meet the Wake Forest University eligibility requirements and submit a complete and accurate Enrollment Application form on or prior to the Effective Date will receive coverage as of the Effective Date determined by the Plan.
4. **Application for Enrollment after the Effective Date of Contract.** Application for enrollment will be permitted within thirty-one (31) days from the date the Employee first meets the eligibility requirements (and waiting period requirements, if any), by completing and submitting an Enrollment Application form to Wake Forest University Coverage for these persons will begin on the day following completion of the waiting period requirements. New employees are eligible for benefits the first of the month coincident with or following their date of hire. If they are transferring into a benefits eligible position then they would be eligible as of the transfer date.
5. **Enrollment During the Plan's Annual Enrollment Period.** Eligible Employees may enroll themselves and family Dependents during an Annual Enrollment Period specified by the Plan.
6. **Enrollment During a Special Enrollment Period.** Employees and Dependents shall also be permitted to enroll during a Special Enrollment Period as defined in this paragraph;

A. Individuals Losing Other Coverage:

Wake Forest University will permit an Employee who is eligible, but not enrolled for coverage (or a Dependent of such an Employee if the Dependent is eligible but not enrolled for coverage) to enroll for coverage if the following conditions are met:

- 1) The Employee or Dependent was covered under a Plan that had health insurance coverage at the time Wake Forest University coverage was previously offered to the Employee or Dependent.
- 2) The Employee stated in writing at such time that coverage under another Group health Plan was the reason for declining enrollment, if required.
- 3) The Employee's Dependent's coverage described in paragraph (1) above –
 - a) was under COBRA continuation provision and the coverage under such provision was exhausted (not simply dropped during applicable COBRA period), or
 - b) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination, or reduction in hours of employment) or employer contributions towards such coverage was terminated.
- 4) the Employee requests such enrollment no later than thirty (30) days after the date of exhaustion of coverage described in (3)(a) or termination of coverage or employer contribution described in paragraph (3)(b).

B. Dependent Beneficiaries – Special Enrollment Period

A Special Enrollment Period also applies if a person has a new Dependent by birth, marriage, adoption, or placement in home in anticipation of adoption or foster care placement. The election to enroll must be made within thirty (30) days following the

birth, marriage, adoption, or placement in home in anticipation of adoption. Foster children shall be treated the same as newborn infants and adoptive children.

An eligible Employee is allowed to enroll when he or she marries or has a new child (as a result of marriage, birth, adoption or placement for adoption). A spouse of an Enrollee can also be enrolled separately at the time of marriage, or when a child is born, adopted or placed for adoption. A child who becomes a Dependent of a covered Employee as a result of a marriage, birth, adoption or placement for adoption can be enrolled when the child becomes a Dependent. Further, a child who becomes a Dependent of an eligible Employee as a result of marriage, birth adoption, or placement for adoption can be enrolled if the Employee enrolls at the same time.

Coverage with respect to marriage shall be effective on the first day of the month after the date the Employee submits a properly completed Enrollment Application form. Coverage with respect to birth, adoption, or placement for adoption shall be effective on the date of birth, adoption or placement for adoption.

To enroll a new spouse or a new Dependent child, you must contact Human Resources within 30 days of acquiring the new Dependent. This applies to a newborn child or an adopted or foster child newly placed in the adoptive/foster home if additional monthly premium will be required when the child is added to the Plan. If no additional monthly premium will be required when you add a Dependent child to the Plan, you should contact Human Resources so that we may send an identification card to facilitate the child's access to Covered Behavioral Health Services.

7. **Late Enrollees.** A Late Enrollee is defined as an individual who enrolls in the Plan at any time other than the periods described in Paragraphs 3 – 6 above. Late Enrollees may enroll in the Plan during the next annual enrollment or within 30 days of a qualifying event, or you may enroll within 60 days of the following events: A) You or your dependents become eligible for premium assistance with respect to coverage under this Plan under Medicaid or the Children's Health Insurance Program (CHIP) or B) You or your dependents lose coverage due to loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).
8. **Enrollment Forms.** For coverage to be obtained, an Enrollment Application form must be completed and returned to Wake Forest University. To enroll a new spouse or a new Dependent child, you must submit an Enrollment form through the Group within 30 days of acquiring the new Dependent. This applies to a newborn child or an adopted or foster child newly placed in the adoptive/foster home if additional monthly premium will be required when the child is added to the Plan. If no additional monthly premium will be required when you add a Dependent child to the Plan, you must complete an Enrollment Form to facilitate the child's access to Covered Behavioral Health Services. A newborn child will be covered from the moment of birth. A foster care or adopted child will be covered from the date of placement in the home. Services may be delayed, with exception to Emergency Services, because of an incomplete Enrollment Application Form.
9. **Notification of Eligibility or Ineligibility.** As an Enrollee in the Wake Forest University plan, you agree to notify Wake Forest in writing at once of any changes in status that affect

you or a family member's eligibility. You can do this by filling out an Enrollment Form and sending it to Wake Forest University Human Resources.

- 10. Adding or Removing a Dependent.** It is your responsibility to notify Wake Forest University and complete any required forms. Failure to notify Wake Forest University in a timely manner could result in loss of eligibility for continuation of coverage.

SECTION TWO: HOW THE PLAN WORKS

1. **The Network.** CBHA provides Network Professionals who meet the criteria for participation as Network Providers. Network Providers can be accessed through Carolina Behavioral Health Alliance's website, www.cbhallc.com or by calling 1-800-475-7900.

Please note: The list of in-network providers may change from time to time, so please verify that the Provider is still in the CBHA network before receiving care.

2. **Your Payments under this Summary Plan Description.** This Summary Plan Description gives you flexible choice in choosing a Network Provider and payment options for Behavioral Health Care Services. Wake Forest University offers a PPO (preferred provider organization) health benefit program. Only services provided by a Provider on the Network are Covered Behavioral Health Care Services. When you choose the PPO benefit, you may be required to share in the cost of Covered Behavioral Health Services by payment of Coinsurance, and/or Deductible. In addition, Benefits in the Wake Forest University program require you to pay a fixed amount, a Copayment, each time you receive a service. All payments by Wake Forest University are subject to the conditions and limitations contained in the Summary of Benefits, which is provided to you with this Summary Plan Description. Please call Wake Forest University if you do not have the Summary of Benefits. The following is an explanation of the cost sharing terms used in this Summary Plan Description and in the Summary of Benefits.

- A. **Deductible.** The Deductible is a certain amount Incurred per year, per person as set forth in your Summary of Benefits.

- 1) **Individual Deductible.** If only one person has coverage, then he or she must incur the Deductible for services given before we begin to pay for Covered Behavioral Health Services.
- 2) **Family Deductible.** No person in a family will have to incur more than the Individual Deductible in a Benefit Year. When your family members' Individual Deductible payments totaled together reach the amount shown on the Summary of Benefits in a year, you will not make any more Deductible payments. Refer to the Summary of Benefits for the Family Deductible amount.

- B. **Co-payment.** A Co-payment is a fixed dollar amount that you must pay each time you receive a particular Covered Behavioral Health Service. The Co-payment applies to your Out-of-Pocket Maximum. Please see the Summary of Benefits for a list of Benefits that have Co-payments.

- C. **Coinsurance.** Coinsurance is a fixed percentage of charges you must pay toward the cost of Covered Behavioral Health Services. We base Coinsurance on the lesser of the allowable charges or Wake Forest University's Maximum Allowable Payment. See your Summary of Benefits for the Coinsurance amounts. The Out of Network Provider may bill you directly for Coinsurance as well as the amount of the difference between his or her charge for such Covered Behavioral Health Services.
- E. **Non-Medically or Psychologically Necessary Services.** We pay only for Covered Behavioral Health Services that are Medically or Psychologically Necessary as defined in Section Three, Paragraph 1, "Medical or Psychological Necessity." If we decide that a service is not Medically or Psychologically Necessary either before or after the Network Provider provides the service, he or she may not bill you.

In these cases, decisions of Medical or Psychological Necessity will be made with the advice of trained Health Professionals. The Health Professionals will use recognized medical standards and criteria. Our decisions will be made after looking at the facts of your situation and care provided to you.

This includes your Provider's reasons for providing or prescribing the care. This also includes any unusual circumstances that are brought to our attention. However, the fact that your Provider prescribes the care or service does not mean that the care automatically qualifies for payment under this Summary Plan Description.

3. **Emergency Services.** If you need Emergency Services, go to the nearest Emergency Room, which can provide the care or treatment you need. If necessary and available, call 911 or use other community emergency resources to obtain assistance in handling life-threatening Emergencies. You will be responsible for the Copayment amount listed on your Summary of Benefits. The emergency room co-payment does not apply if you are held for observation or are admitted to the hospital after receiving emergency services in the emergency room. If you are held for observation, outpatient benefits apply to all covered services received in both the emergency room and during observation. If you are admitted to the hospital from the emergency room immediately following emergency services, inpatient benefits apply to all covered services received in both the emergency room and during the inpatient hospitalization. An "Emergency Mental Health and Substance Abuse Condition" means the sudden or unexpected onset of a mental or substance abuse condition requiring immediate mental health or substance abuse treatment which you secure after the onset of such condition, and that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention to result in any of the following:

- ♦ serious physical impairment or death;
- ♦ serious or permanent dysfunction of your mental health; or
- ♦ your or a third party's health placed in serious jeopardy

Wake Forest University provides coverage for Emergency Service. "Emergency Services" means Medically or Psychologically Necessary Services furnished or required

to screen for or treat an Emergency Mental Health or Substance Abuse Condition until the condition is Stabilized.

4. **Emergency Admissions.** An “Emergency Admission” is an admission to an inpatient Facility after Stabilization. If, after Stabilization, you are admitted through the Emergency Room, please call CBHA as soon as reasonably possible. You should call us and inform us of your condition and the services you are receiving within 48 hours or by the close of the first business day. You may call us at 1-800-475-7900. Once you are admitted to an out-of-network Hospital on an emergency basis, your Benefits will be paid like any in-network Hospital admission. However, you may need to transfer to an in-network Hospital once your condition has been Stabilized in order to continue receiving in-network Benefits. Please refer to your Summary of Benefits for the appropriate co-payments, Deductible, and Coinsurance amounts.

Services provided in an Emergency Room that do not meet the definition of Emergency, will be covered as an outpatient service.

Follow-up care for emergencies must be provided by an in-Network Provider in order to receive Benefits.

5. **Coverage While Traveling.** When you are traveling out of our Service Area for some purpose other than to receive medical or psychological care, we may pay in-network Benefits if:
 - ♦ If services are deemed Emergency Services;
 - ♦ You could not have reasonably foreseen the condition;
 - ♦ You could not reasonably return to our Service Area to receive treatment from a Behavioral Health Care Service Network Provider;
 - ♦ Our Medical Director agrees that the treatment was Medically or Psychologically Necessary;
 - ♦ You or your representative calls us at 1-800-475-7900 within 48 hours or by the close of the first business day after the rendering of care; and
 - ♦ You submit for review all claims and proof of service to us in writing within twelve months after the date of service.

CONTACT CBHA AT 1-800-475-7900 FOR MORE INFORMATION CONCERNING OUR SERVICE AREA.

6. Notice Of Benefit Determination

CBHA will provide an explanation of benefits determination to the *member* or the *member's* authorized representative within 30 days of receipt of a notice of claim if the *member* has

financial liability on the claim other than a *co-payment* (unless your *Plan* has chosen to provide an explanation of benefits for additional claims where the *member* does not have a financial liability other than a *co-payment*). CBHA may take an extension of up to 15 more days to complete the benefits determination if additional information is needed. If CBHA takes an extension, CBHA will notify the *member* or the *member's* authorized representative of the extension and of the information needed. You will then have 90 days to provide the requested information. As soon as CBHA receives the requested information, or at the end of the 90 days, whichever is earlier, CBHA will make a decision within 15 days.

Such notice will be worded in an understandable manner and will include:

- The specific reason(s) for the denial of benefits
- Reference to the benefit booklet section on which the denial of benefits is based
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed
- A description of the review procedures and the time limits applicable to such procedures, including the *member's* right to bring a civil action under Section 502(a) of *ERISA* following a denial of benefits
- A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request
- If the denial of benefits is based on *medical necessity* or *experimental* treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the *member's* medical circumstances, or a statement that this will be provided without charge upon request; and
- In the case of a denial of benefits involving *urgent care*, a description of the expedited review process available to such claims.

IF YOU DISAGREE WITH OUR DETERMINATION OF MEDICAL OR PSYCHOLOGICAL NECESSITY, YOU OR YOUR BEHAVIORAL HEALTH PROVIDER SHOULD CALL CAROLINA BEHAVIORAL HEALTH ALLIANCE IMMEDIATELY AT 1-800-475-7900.

We will discuss your concerns with you and your Provider and review our decision. We will tell you promptly of our decision after completing our review.

Upon receipt of a denial of benefits, you have the right to file an appeal with CBHA. Please follow the procedures for filing Grievances and Appeals as described in Section Ten, "Grievances and Appeal Process."

SECTION THREE: BEHAVIORAL HEALTH CARE

Important Note: All payments by Wake Forest University are subject to the conditions and limitations contained in the Summary of Benefits, which is provided to you with this Summary Plan Description. Please call Wake Forest University if you do not have the Summary of Benefits.

A network of **outpatient** mental health and chemical dependency providers is available to you. This network includes psychiatrists, licensed clinical psychologists, licensed professional counselors, licensed clinical social workers, psychological associates, certified fee-based practicing pastoral counselors, clinical nurse specialists, licensed marriage and family therapists, and certified clinical addictions specialists and certified substance abuse counselors. A complete list of Network Providers is available at www.cbhallc.com. From the home page, select “enrollees” then click “find a provider”. You will have the ability to search the network for a provider by name, address, zip code, provider type, and clinical expertise. For further assistance in locating an outpatient provider you may also contact Carolina Behavioral Health Alliance, the behavioral health plan administrator, by calling (800) 475-7900. Please see the Summary of Benefits for your cost sharing amounts and maximum payment amounts.

All hospital or inpatient facilities, residential facilities, partial hospitalizations, or intensive outpatient programs REQUIRE prior authorization. Prior to your admission to one of these levels of care you must call us at (800) 475-7900. We will assist in identifying and referring you to an in-network facility based on your needs and preferences. If you fail to call, you have no coverage for Behavioral Health Services unless your condition renders you unable to comply with the notification requirement and your condition meets the criteria of an Emergency Admission as described in Section 2 Paragraph 4. Please refer to the Summary of Benefits for the co-payment and Coinsurance amounts that apply to inpatient admissions.

1. Medical or Psychological Necessity. We will pay for those services that are Medically or Psychologically Necessary. For this Section, “Medically or Psychologically Necessary” means Covered Behavioral Health Services;

- ♦ Necessary and appropriate for the diagnosis, evaluation or treatment of a mental health or substance abuse (chemical dependency) condition or illness other than developmental disorders, communications disorders, disorders of early childhood and infancy with a distinct DSM-IV diagnosis;
- ♦ Reasonably expected to improve the individuals condition or level of functioning or at least prevent further deterioration;
- ♦ Provided at a level of care appropriate to the severity of the patient’s illness and capacity to respond to professionally provided treatment;
- ♦ Consistent with generally accepted standards of mental Health Professional practice (psychiatry, clinical psychology, clinical social work) in the community;
- ♦ Within the professional competence of the Provider;
- ♦ Not for experimental, investigational or cosmetic purposes; and

- ♦ Not solely for the convenience of you, your family or the Provider.
2. **Levels of Treatment.** We will pay for the following levels of service when Medically or Psychologically Necessary:
- A. **Inpatient Facility – Acute Care Programs or Units.**
- ♦ Free-Standing Facility – A licensed Facility that focuses on psychiatric or substance abuse treatment, which is not associated with a medical Hospital. To be considered for coverage, an inpatient facility must be licensed as such in the state in which it operates and be accredited by JCAHO, CARF or COA.
 - ♦ General Hospital-A facility which meets the definition of a hospital, is licensed in the state in which it operates as a hospital and is accredited by JCAHO, CARF or COA.
- B. **Acute Residential Care Facility-** A licensed Facility that focuses on psychiatric or substance abuse treatment. A facility must meet the definition of a hospital, including providing 24-hour on site nursing by a graduated registered nurse with physicians providing coverage at a minimum of a weekly basis. Residential care facilities are not required to maintain facilities for major operative surgery. Residential programs must monitor patients at least weekly for continued stay criteria and will not be considered for coverage if they adhere to a pre-set number of days in a program. Care in a residential care facility must be under the direction of a board eligible or board certified psychiatrist or general psychiatrist. To be considered for coverage, an acute residential care facility must be licensed as such in the state in which it operates and be accredited by JCAHO, CARF or COA.
- C. **Partial Hospital Day and Evening Programs, or Intensive Outpatient Programming.** These are programs provided by an inpatient Hospital or free-standing Facility whereby a patient with psychiatric or substance abuse illnesses may participate in individual or Group therapy programs without remaining overnight at the Facility. Patients in such programs generally return to their own living quarters each day or evening after the program. Partial Hospitalization services is four to eight hours of treatment in any one day and intensive outpatient services is 2 to 4 hours of treatment in any one day. To be considered for coverage, a partial hospitalization or intensive outpatient program must be licensed as such in the state in which it operates (if applicable) and be accredited by JCAHO, CARF or COA.
- ♦ Licensed Hospital based programs-All such programs must be operating in a facility licensed as a hospital and accredited by JCAHO, CARF or COA.
 - ♦ Free-Standing programs-All Free-Standing programs must be licensed appropriately in the state in which they operate and be accredited by JCAHO, CARF or COA.
- D. **Outpatient.** Evaluation and diagnosis, individual and family counseling, Group therapy and medication management are covered professional services. Outpatient network provider directory can be found at www.cbhallc.com or for assistance you may call (800) 475-7900.
3. **Applied Behavioral Analysis/Adaptive Behavioral Treatment. (ABA/ABT)**

A board certified applied behavioral analyst that focuses on providing medically necessary adaptive behavioral treatment for individuals who have been formally diagnosed with an autism spectrum disorder. Please see summary of benefits for your cost sharing amounts and plan limits specific to ABA/ABT.

4. Determination of Appropriate Levels of Treatment. In determining our payment for the cost of “appropriate levels of treatment” we consider the following criteria:

- ♦ The intensity and scope of care; and
- ♦ The least restrictive environment that will provide adequate care with the least disruption to you, your family, work, school, etc. The level of treatment should offer the best opportunity for independent or community assisted functioning.

5. Inpatient Care for Mental Health Treatment.

We will pay for inpatient mental health treatment if it is preauthorized and meets Medical or Psychological Necessity requirements. Deductible and Coinsurance requirements may apply. Partial Hospitalization and Intensive Outpatient Programs are covered under the inpatient benefits. Please see the Summary of Benefits for your cost sharing amounts and Plan limits.

You or your provider must call 1-800-475-7900 within 48 hours of your admission to notify us of your inpatient admission, residential admission, partial Hospitalization admission, and intensive outpatient programming admission. In order to receive Benefits, you or your Provider must call CBHA at 1-800-475-7900 for Certification. If Certification is not received, you have no coverage for Behavioral Health Services unless your condition renders you unable to comply with the notification requirement and your condition meets the criteria of an Emergency Admission as described in Section 2 Paragraph 4. Please refer to the Summary of Benefits for the co-payment and Coinsurance amounts that apply to inpatient admissions.

6. Outpatient Care for Mental Health Treatment.

We will pay for Medically or Psychologically Necessary outpatient care if care is Medically or Psychologically Necessary. Please refer to your Summary of Benefits for the amounts of your copayments, coinsurance and deductibles.

7. Chemical Dependency Treatment. “Chemical Dependency” means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal. We will pay for short-term crisis intervention treatment, and for inpatient, residential, partial Hospitalization, intensive outpatient programming or outpatient services that are Medically or Psychologically Necessary. Please refer to your Summary of Benefits for the Plan co-payments, coinsurance and deductibles.

You or your provider must call 1-800-475-7900 within 48 hours of your admission to notify us of your inpatient admission, residential admission, partial Hospitalization admission, and intensive outpatient programming admission. If you fail to call, you have no coverage for chemical dependency services unless your condition renders you unable to comply with the notification requirement and your condition meets the criteria of an Emergency

Admission as described in Section 2 Paragraph 4. Please refer to the Summary of Benefits for the co-payment, Deductible, Coinsurance that apply to chemical dependency treatment.

8. Emergency Care Not Referred through the Network. Please refer to Section Two, paragraph 3 “Emergency Care” and paragraph 4 “Emergency Admission” for a discussion of procedures to follow in the event of an emergency or emergency admission.

9. Out-of-Network Services: Services rendered by a provider who is not credentialed by CBHA may be covered under “out-of-network” benefits, if your plan provides this coverage. Please refer to your Summary of Benefits for details.

SECTION FOUR: EXCLUSIONS MENTAL HEALTH AND SUBSTANCE ABUSE PLAN EXCLUSIONS AND LIMITATIONS

Charges for the following are not covered:

Acupuncture; acupressure, hypnosis, hypnotherapy, biofeedback, massage therapy.

Administrative costs for completing claim forms or reports; for providing medical records requested by the Plan; postage, shipping and handling charges; interest or financing charges; telephone calls, conferences consultations or therapy sessions via internet except for telemedicine conferencing.

Ambulance services are not covered under the mental health and substance abuse benefits of the plan. These services may be covered under the medical portion of your plan.

Appointments. Charges for broken or missed appointments.

Charges for Missed or Canceled Appointments. We will not pay for charges for appointments that you miss or cancel.

Chronic Pain. We will not pay for services related to the treatment of chronic pain by any means other than psychotherapy if it is determined that such pain has psychological origin.

Complications arising from non-covered services or treatment. No benefits are payable for any care, treatment, services or supplies, whether or not prescribed by a Physician, for complications from a non-covered condition.

Concurrent Care. The same service provided by more than one provider concurrently or a single provider providing the same service more than once in the same day. An exception is made to cover concurrent care that is pre-certified by CBHA as medically necessary for the treatment of the patient.

Cosmetic surgery (elective) or other services and supplies that improve, alter or enhance appearance, whether or not for psychological reasons.

Custodial care. Services and supplies, including confinement, that are provided to an individual primarily to assist with his/her daily living activities. Custodial care includes assisting in activities of daily living such as walking, getting in and out of bed, bathing, dressing, eating and taking medications. The Plan will not pay for Hospital care, nursing home or Skilled Nursing facility care, home care, or a school or other institution for behavior and/or developmental modification or care, or any other service that is custodial or respite care in nature.

Detoxification Treatment. Detoxification treatment provided on a medical unit. However, such treatment is covered under your Group's medical Benefits Plan as determined to be Medically Necessary, subject to the limitations contained in the Summary of Benefits for your Benefits Plan.

Developmental Disorders and Learning Disorders. The plan will not pay for treatment for developmental disorders, communication disorders or learning disorders.

Disorders of Infancy or Early Childhood. The plan does not cover treatment for Intellectual developmental disorders, Learning Disorders, Motor Skills Disorders, Communication Disorders, Pervasive Developmental Disorders, Feeding and Eating Disorders of Infancy or Early Childhood, Tic Disorders, Elimination Disorders, Stereotypic Movement Disorder or Disorders of Infancy, Childhood or Adolescence Not Otherwise Specified in the absence of a covered mental illness.

Educational or vocational testing. Services for educational or vocational testing or training, other than testing for learning disorders.

Excess charges. The part of an expense for care and treatment of an Injury or Illness that is in excess of the CBHA allowed amount. The allowed amount is determined by the negotiated fees CBHA pays its contracted providers for the same service in your area.

Experimental and/or Investigational. Experimental or Investigational means any supply, medicine, facility, equipment, service, or treatment that:

- Is not currently or at the time the charges were incurred recognized as acceptable medical practice by the Plan as determined by CBHA Medical Management staff or qualified outside medical reviewers.
- A drug or device that must have Food and Drug Administration (FDA) approval for those specific indications and methods of use for which such drug or device is sought to be provided, subject to medical judgment of CBHA Medical Management staff or qualified outside medical reviewers.

Educational or Informational Sessions. Sessions for relatives of a patient receiving Mental Health or Substance Abuse treatment that are conducted for educational or informational purposes.

Foreign travel. Care, treatment or supplies outside of the United States if travel is for the sole purpose of obtaining medical services.

Government Programs. For any condition, disease, ailment, injury or diagnostic service to the extent that Benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law. We will not pay for treatment of disabilities from diseases contracted or injuries sustained as a result of military service or any act of war, declared or undeclared.

Holistic or homeopathic medicine. nurse, therapist, etc.) who is an employee of a Medical Care facility and whose services are paid by the Medical Care facility.

Instructional Programs. We will not pay for instructional or educational programs such as, but not limited to, adoption counseling, vocational training and testing, employment counseling or smoking cessation classes.

Lack of Licensure. Services by a provider that is not licensed to independently provide the services rendered in the place where the services occurred.

Mandated or Court-Order Care. The Plan will not pay for any medical, psychological or psychiatric care that is the result of a court order or mandated by a third party (such as, but not limited to your Employer, licensing board, recreation council or school), unless it is Medically or psychologically Necessary, or court-ordered pursuant to a Qualified Medical Child Support Order.

Marital or pre-marital counseling. We will not pay for marriage or relationship, counseling and similar counseling for conditions not attributable to a mental disorder.

No charge. Confinement, treatment or services for which the Plan Participant has no financial liability, or that would be provided at no charge in the absence of insurance coverage or for which the Plan has no legal obligation to pay.

Non-Medically Necessary. We will not pay for services that are not medically necessary.

Not specified as covered. Non-traditional services, treatments and supplies which are not specified as covered under this Plan.

Nutritional Counseling/Programs. Care and treatment of obesity, weight loss or dietary control, whether or not related to an illness, is not covered under the Behavioral Health Benefits of the Plan. Also excluded are nutritional consultations, recreation therapy, education therapy, self-help training and supplies.

Obesity. We will not pay for Behavioral Health Care Services meant for the control of obesity.

Occupational. Care and treatment of an Illness that is occupational—that is, arises from work for wage or profit including self-employment. The Plan will not pay if you are eligible to receive

payment under a Worker's Compensation law or similar legislation, regardless of whether or not you make a claim or receive compensation.

Plan design excludes. Charges excluded by the Plan design as described in this document.

Rehabilitative Treatment. We will not pay for rehabilitative treatment associated with permanent or temporary disability resulting from an accident or injury in circumstances where such treatment is part of a comprehensive rehabilitation program.

Reimbursement. Treatment received or expenses incurred by a Plan Participant that are reimbursed, entitled to reimbursement, or are in any way indemnified by or through any public program except when this Plan is required by Federal Law to pay as primary. This exclusion includes confinement, treatment or services paid for or furnished by the United States Government or one of its agencies; but, does not apply to Medicaid or when otherwise prohibited by law.

Relative giving services. Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Remedial Education. We will not pay for remedial education, including services for learning and behavioral disabilities.

Required Examinations. We will not pay for exams for obtaining or maintaining employment, insurance or professional or other license.

Research or Study. We will not pay for any services in connection with research or study.

Residential treatment facilities. Residential treatment is not covered for the following types of care:

- Foster homes or halfway houses
- Wilderness Center training
- Therapeutic boarding schools
- Custodial care, situation or environmental change

Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ended under this Plan.

Sex Offenders. We do not cover programs for the treatment of sexual offenders or perpetrators of sexual or physical violence.

Sex Therapy Programs. We will not pay for sex therapy programs or psychotherapy for problems related to sexual dysfunction.

Services for Secondary Conditions. Services rendered for secondary conditions, including V Codes, in the absence of a current illness or injury.

Sleep Disorders, Neurological Disorders and Dementia are excluded under the mental health and substance abuse benefits. These may be covered under the medical portion of your plan.

Special Education. The Plan does not pay for any form of special education such as music therapy, remedial reading, recreational or activity therapy, or equipment or supplies used similarly.

Smoking Cessation/ Nicotine/Caffeine/Gambling Addiction or other process addiction, such as Internet usage or Sex. Care and treatment for smoking cessation, nicotine, caffeine or gambling addiction or other process addictions is not covered under the mental health and substance abuse benefits.

Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated in this **Summary Plan Description**.

War. Charges incurred as a result of war or any act of war, whether declared or undeclared, or for service related charges incurred while serving in the armed forces of any country except for Post Traumatic Stress Disorder (PTSD).

Worker's Compensation. We will not pay for any care or supplies for any injury, condition or disease if you may receive payment under a Workers' Compensation Law or similar legislation.

IF YOU HAVE ANY QUESTIONS ABOUT BENEFITS OR COVERAGE, PLEASE CALL US AT 1-800-475-7900.

SECTION FIVE: COORDINATION OF BENEFITS (COB)

If the Enrollee covered under this Summary Plan Description or any enrolled Dependents or enrolled spouse has coverage under Wake Forest University and another Health Care Benefits Plan, and receives services that are covered by both Plans, we will coordinate Benefits. The coordination of Benefits ("Coordination of Benefits" or "COB") rules determine which Health Care Benefits Plan is:

- ♦ Primary – must apply its Benefits to the payment of services first
- ♦ Secondary – must apply its Benefits to the payment of services after the primary Plan's Benefits have been applied.

The Plan that pays first according to the rules will pay as if there were no other Plan involved. The secondary and subsequent Plans will pay the balance due, up to the total allowable expenses.

Coordination of Benefits prevents duplication of payment and overpayments for services given.

1. **Health Care Benefits Plan.** For this Section only, "Health Care Benefits Plan" means any of the following (including Wake Forest University), which provide Benefits or services for medical or psychological care or treatment:

- A. Coverage under government programs (other than Medicaid), including Medicare, required or provided by law.
 - B. True Group Insurance, which includes prepayment, Group practice or individual practice coverage. It does not include school accident-type coverage, blanket, franchise individual, automobile and homeowner coverage.
 - C. The term “Health Care Benefits Plan” will be interpreted separately with respect to:
 - ♦ That part of any such policy, Contract or other arrangement that has the right to take the Benefits of the other Health Care Benefits Plan into consideration in determining its Benefits and that part that does not take such Benefits into consideration.
2. **Allowable Expense.** For this Section only, “Allowable Expense” means the lowest amount of charges, between the two Plans, that you are required to pay.

When a Health Care Benefits Plan provides Benefits in the form of services rather than cash payments, the reasonable cash value of the service will be an Allowable Expense and a Benefit paid.

3. **Provider Contract Agreement.** When coordinating Benefits with another Plan, Wake Forest University will not pay for any charges that a Provider agrees to write off due to a Contract agreement with another Plan.
4. **Coordination of Benefits.** We have the right to coordinate Benefits between Wake Forest University and any other Health Care Benefits Plan covering you. If this happens, payment under the two or more Plans will not exceed 100% or your actual Allowable Expenses.

One Plan (the primary Plan) will pay its full Benefits. The other Plan (the secondary Plan) may pay any Allowable Expenses in excess of the primary Plan Benefits, up to the maximum amount that it would pay if the COB provision were not in force.

Benefits are coordinated on a claim-by-claim basis. Benefit credits are not accumulated or used on other claims.

When Wake Forest University is the primary Plan; we will provide the full extent of Benefits under this Summary Plan Description.

When Wake Forest University is the secondary Plan, we will pay Benefits coordinated with the primary Plan so that the two Plans will pay up to the amount of the patient’s Allowable Expenses. The order of payment is determined as follows:

- A. The Plan without COB will be the primary Plan.
- B. If the patient is covered as an Employee under one Plan and as a Dependent under the other, then the primary Plan will be the one under which the person has coverage as an Employee.
- C. If the patient is a Dependent child with coverage under both parents’ Plans, the Plan of the parent whose birthday falls earlier in the year will be the primary Plan. If both parents have the same birth (only the month and day are used), the Plan that covered the

Dependent longer will be the primary Plan. If one Plan does not have this rule, but has another rule and as a result the Plans do not agree on which is primary, then the father's Plan will be the primary Plan.

The following guidelines apply in cases of divorce or separation:

- ♦ When the court decree states which parent has financial responsibility for the child's health care expenses, then that parent's Plan will be the primary Plan;
- ♦ When financial responsibility has not been decided, then the Plan which covers the child of a parent with legal custody will be the primary Plan;
- ♦ When financial responsibility has not been decided, there is no court order for the maintenance of healthcare and the parents have joint custody, default to the Birthday rule; and
- ♦ When financial responsibility has not been decided, and the parent with legal custody remarries and the stepparent's Plan also covers the child as a Dependent, the order of primary coverage is as follows:

- 1) the Plan of the parent with legal custody
- 2) the Plan of the spouse of the parent with custody
- 3) the Plan of the parent without legal custody

D. If one health Plan is a Retirement Plan and the other is the Plan where a person has active employment (the "Active Plan"), then the Active Plan is the primary Plan and the Retirement Plan is the secondary Plan. This is true for Dependents also, even if the Dependent is the retiree under the other Plan.

E. If a Group health Plan covers an individual as an active Employee (or as the Dependent of an active Employee), it shall be the primary Plan if the individual also has continuation of coverage under COBRA.

F. Liability insurance, such as worker's compensation, employer liability, auto liability, active duty military health Benefits, are primary to CBHA coverage. Medicare Coordination of Benefits apply in determining if Medicare is primary.

G. If none of the rules for order or payment apply, then the Plan under which the Enrollee has been enrolled the longest will be the primary Plan.

5. **Payments to Other Health Benefits Programs.** If we repay any other Health Care Benefits Plan the amount it paid for your Covered Behavioral Health Services, then these payments are the same as Benefits paid. This will satisfy our obligation to the Enrollee, covered Dependents, and covered spouses under this Summary Plan Description.
6. **Our Rights to Recover Overpayment.** In some cases, we may pay in error, such as, where you had coverage under another Health Care Benefits Plan. In such a case, you will have to refund to us the payment. We also have the right to recover the mistaken payment from the other Health Care Benefits Plan if they have not repaid us. You agree to take such actions,

which we may require to help us recover an overpayment or mistaken payment or overpayment.

As permitted by law, we may reduce our future payments to you or the Provider so that we may recover a mistaken payment or overpayment.

PLEASE CALL CBHA AT 1-800-475-7900 IF YOU HAVE QUESTIONS ABOUT COORDINATION OF BENEFITS.

SECTION SIX: PROTECTED HEALTH INFORMATION

Disclosure Of Protected Health Information (PHI)

Wake Forest University takes your privacy seriously and handles all PHI as required by state and federal laws and regulations and accreditation standards. Wake Forest University has developed a privacy notice that explains the procedures. To obtain a copy of the privacy notice, contact Wake Forest University Human Resources at AskHR@wfu.edu or 336-758-4700.

Medical or psychological records and other information about your care that CBHA receives from Providers are confidential. We will use such information only to:

- Administer your coverage;
- Review Referrals to other Providers;
- Perform Case Management;
- Conduct quality assurance and Utilization Review;
- Process claims for payment; **or**
- Give utilization information to your treating Providers.

We will disclose such information to others only as needed to coordinate Benefits, to assure continuity of care to review claims and utilization information with your Provider indicating inappropriate use of Benefits, as required by law, or with your written consent.

SECTION SEVEN: TERMINATION OF MEMBER COVERAGE

Your coverage under Wake Forest University will end in certain conditions. These conditions are described below.

- A. **Nonpayment of Premiums.** Your coverage will end if you have failed to make any required contributions for coverage. Benefits for you and your Dependents will be terminated as of the last day for which premium payments were paid.
- B. **Eligible Class-** If you change to an employee class that is no longer eligible for benefits, you and your dependents coverage will terminate.
- C. **Termination of the Plan-** If Wake Forest University terminates the Plan, you will no longer be eligible for benefits covered by the Plan.
- D. **Termination from employment-** If you are terminated from employment for any reason, your coverage will end at the end of the month of your termination.
- E. **Failure to meet the “actively-at-work” criteria** (unless otherwise defined by the continuation of coverage provisions).
- F. **When you voluntarily terminate coverage,** you will no longer be covered by the benefits.

Refer to Section Eight, “Continuation of Coverage”, for the circumstances in which you, your covered spouse and your covered Dependents may continue Wake Forest University coverage.

Other Terminating Events

A. Termination For Cause

An Enrollee’s coverage may be terminated upon 30 days prior written notice for the following reasons:

- The Enrollee fails to pay or to have paid on his or her behalf or to make arrangements to pay any Copayments, Deductible or Coinsurance for services covered under the Plan
- No Network Provider is able to establish or maintain a satisfactory doctor-patient relationship with an Enrollee, as determined by the Plan
- A Enrollee exhibits disruptive, abusive, or fraudulent behavior toward a Network Provider.
- As an alternative to termination as stated above, the Plan, in its sole discretion, may limit or revoke an Enrollee’s access to certain Network Providers.

B. An Enrollee’s coverage under the Plan will be terminated immediately for:

- Fraud or material misrepresentation by the Employee or Dependent
- The Enrollee permits the use of his or her or any other Enrollee’s ID card by any other person not enrolled under this Plan, or uses another person’s ID card.

If such termination is made retroactively to the effective date of your policy (called a rescission),

you will be given 30 days advance written notice of this rescission and may submit a grievance-see “Grievance and Appeal Process.” If your policy is rescinded, any premiums paid will be returned unless the Plan deducts the amount for any claims paid.

SECTION EIGHT: CONTINUATION OF COVERAGE

Under certain circumstances, your eligibility for coverage under this *Plan* may end. You may have certain options such as continuation on Family Medical Leave, other leave of absence, enrolling in Medicare or continuing health insurance under this *Plan in accordance with Federal Law (COBRA)*. Read this section to find out what your options are regarding continuation.

Family Medical Leave Act (FMLA)

Wake Forest University does comply with the Family Medical Leave Act (FMLA).

Leave of Absence

Coverage may continue during paid leaves of absence that offer benefits. If you are on a leave of absence that does not offer benefits, you may elect to access COBRA. Contact the Wake Forest University Human Resources Department for information regarding leave of absence allowances for further details.

Medicare

When you reach age 65, you may be eligible for Medicare Part A hospital, Medicare Part B medical, and Medicare Part D prescription drug benefits. You may be eligible for Medicare benefits earlier if you become permanently disabled or develop end-stage renal disease. Just before either you or your spouse turn 65, or when disability or end-stage renal disease occurs, you should contact the nearest Social Security office and apply for Medicare benefits. They can tell you what Medicare benefits are available. If you are covered by this *Plan* when you become eligible for Medicare, consult the *Plan Administrator*, who will advise you about continuation of coverage under the *Plan*.

Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) as provided in Section 4980B of the Code and Part 6 of Title 1 of ERISA, as the same may be amended from time to time. To the extent required by COBRA and other applicable law, upon the occurrence of a “qualifying event” (as defined) gives you right to elect continuation coverage under Wake Forest University when coverage would otherwise end. This Section intends to summarize these rights generally, but not exclusively. If any part of this Section conflicts with any part of any applicable law, the law or regulation shall control.

Under a federal law known as COBRA, if your *employer* has 20 or more employees, you and your covered *dependents* can elect to continue coverage for up to 18 months by paying applicable fees to the *employer* in the following circumstances:

- Your employment is terminated (unless the termination is the result of gross misconduct)
- Your hours worked are reduced, causing you to be ineligible for coverage.

In addition to their rights above, *dependents* will be able to continue coverage for up to 36 months if their coverage is terminated due to:

- Your death
- Divorce or legal separation
- Your entitlement to Medicare
- A *dependent child* ceasing to be a *dependent* under the terms of this coverage.

Children born to or placed for adoption with you during the continuation coverage period are also eligible for the remainder of the continuation period.

If you are a retired *employee* and your *employer* allows coverage to extend to retirees under this *Plan*, and you, your spouse and your *dependents* lose coverage resulting from a bankruptcy proceeding against your *employer*, you may qualify for continuation coverage under COBRA. Contact the *Plan Administrator* for conditions and duration of continuation coverage.

In addition, you and/or your *dependents*, who are determined by the Social Security Administration to be disabled, may be eligible to extend their 18-month period of continuation coverage, for a total maximum of 29 months. The disability has to have started at some time before the 60th day of continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Notice must be provided to the *Plan Administrator* within 60 days of the determination of disability by the Social Security Administration and prior to the end of the original 18-month period of continuation coverage. In addition, notice must be provided to the *Plan Administrator* within 30 days after the later of the date of determination that the individual is no longer disabled or the date of the initial notification of this notice requirement.

You or your *dependents* must notify the *Plan Administrator* within 60 days of the following qualifying events:

- Divorce
- Legal separation
- Ineligibility of a *dependent child*.

You and/or your *dependents* will be offered continuation coverage within 14 days of the date that the COBRA administrator is notified of one of these events resulting in the termination of your coverage. Eligible persons have 60 days to elect or reject continuation coverage. Following election, applicable fees must be paid to the COBRA administrator within 45 days. Continuation coverage will end at the completion of the applicable continuation period or earlier if:

- Your *employer* ceases to provide a health benefit plan to *employees*
- The continuing person fails to pay the monthly fee on time

- The continuing person obtains coverage under another group plan, unless the new group plan excludes or limits coverage for *pre-existing conditions* and the continuing person does not have enough prior *creditable coverage* to satisfy any new waiting period for *pre-existing conditions* that would apply. (In this case, continuation coverage will be the secondary payer, with the exception of claims for *pre-existing conditions*. Continuation coverage will be the primary payer of claims for *pre-existing conditions*.)
- The continuing person becomes entitled to Medicare after the election of continuation coverage.

If you are covered by the *Plan* and called to the uniformed services, as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA), consult the *Plan Administrator*. The *Plan Administrator* will advise you about the continuation of coverage and reinstatement of coverage under this *Plan* as required under USERRA. If you have any questions about your COBRA rights or continuation of coverage, please contact the *Plan Administrator*.

SECTION NINE: UTILIZATION REVIEW

To make sure you have access to high quality, cost-effective Behavioral Health Care, the Plan has a Utilization Management (UM) program. The UM program requires that Behavioral Health Care Services you receive be certified by CBHA in order to receive benefit coverage. As part of this process, CBHA looks at whether Behavioral Health Care Services are Medically Necessary, provided in the proper setting and for a reasonable length of time. **The Plan will honor a Certification to cover Behavioral Health Care Services under the Plan unless the Certification was based on a material misrepresentation about your health condition or you were not eligible for these services under the Plan.**

The CBHA Utilization Management Program (UM) establishes consistent, clinically appropriate guidelines to ensure Enrollees have equitable access to high quality Behavioral Health Care and treatment based upon Medical Necessity and individual need.

The CBHA Utilization Management Program appropriately matches Enrollees to the behavioral health clinicians and programs that are best qualified to meet their clinical needs.

The overall goal of CBHA's Utilization Management Program is to ensure that Enrollees receive the most efficient and effective behavioral health treatment available while using their Benefits wisely.

The CBHA Utilization Management Program is based on the following objectives:

- To ensure Enrollees receive quality care at the most appropriate level;
- To maintain Enrollee confidentiality;
- To conduct prompt and thorough assessments;
- To ensure availability of Emergency Services and crisis intervention 24 hours a day, 7 days a week;
- To facilitate easy access to needed services, including timely outpatient appointments;
- To maintain ongoing responsiveness to individual needs;

- To encourage multi-disciplinary treatment Planning provisions with focused, goal oriented treatment;
- To develop mechanisms for systematic monitoring of treatment outcomes;

The CBHA Medical Director has the overall responsibility for the implementation of the CBHA Utilization Management Program. Any changes in UM program policies and procedures must be reviewed and approved by the Medical Director prior to implementation.

The CBHA Utilization Management program relies on licensed clinical professionals to make determinations of Medical Necessity for behavioral health services for Enrollees:

The CBHA Medical Director and Assistant Medical Director are Board Certified in Adult and/or Child and Adolescent psychiatry. The Medical Director and/or Assistant Medical Director:

- Are to be consulted whenever there is some question of Medical Necessity;
- Review and approve all denials for Medical Necessity;
- Review Grievances and Appeals related to Medical Necessity determinations;
- Conduct peer-to-peer reviews.

CBHA has access to a number of other practitioners (psychiatrists or licensed clinical psychologists) for consultation purposes to review a course of treatment or to provide a Second Opinion. These individuals are required to meet the CBHA credentialing requirements in order to review Medical Necessity determinations.

Clinical Case Managers are licensed clinicians who are delegated the day to day responsibility for all UM activities including the determination of Medical Necessity based upon written criteria for each level of care. They are also responsible to review the UM program on an ongoing basis to assure accuracy and consistency. Clinical Case Managers may include: Licensed Clinical Social Workers; Registered Nurses; Licensed Professional Counselors; Licensed Psychological Associate or other licensed professionals in a related field.

CBHA's Utilization Management Program and Medical Necessity criteria have been established under the guidance of the Medical Director. UM criteria have been adapted from guidelines identified in Milliman and Robertson, Inc. (Healthcare Management Guidelines); the American Psychiatric Association (APA); the American Academy of Child & Adolescent Psychiatry (AACAP); the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) developed by the American Association of Community Psychiatrists; and the American Society of Addiction Management (ASAM).

Specific criteria have been developed in relation to each level of care serving to further define and guide determination of Medical Necessity for that level of care.

Copies of clinical criteria are available to Enrollees and Providers upon request. Medical Necessity and clinical criteria are reviewed annually by the Medical Director.

CBHA utilizes seven different criteria in determining Medical Necessity for any given level of care:

- Services can be reasonably expected to improve the Enrollee's condition or level of functioning, or at least prevent further deterioration;
- The services are provided at the level of care appropriate to the severity of the Enrollee's illness and capacity to respond to professionally provided treatment;
- The services are consistent with generally accepted standards of behavioral Health Professional practice in the community;
- The services are provided within the professional competence of the Provider;
- The services are not for experimental, investigational or cosmetic purposes;
- The services are not solely for the convenience of the Enrollee, the Enrollee's family or the Provider.

An Enrollee or Provider may access CBHA's system of care by calling 1-800-475-7900, a 24 hour, 7 day a week toll-free emergency care/clinical Referral line or may seek direct Emergency Services through the nearest emergency facility.

Transitional Care

Transitional care is a process that allows Enrollees to continue receiving care from a Non-Participating Provider, when Wake Forest University changes behavioral Health Benefit Plan administrators or when their Provider is no longer in the CBHA network.

Transitional care must be Certified by CBHA and the Enrollee will only be responsible for the Deductible, Co-payment and Coinsurance amounts allowed for in-network services for the period allowed by the Plan. Wake Forest University allows a transitional period of 5 visits or 90 days, whichever comes first. Transitional care will not be provided when the Provider's Contract was terminated for reasons relating to quality of care or fraud. Such a decision will not be reviewed on Appeal. Please call CBHA Customer Services at **1-800-475-7900** for additional information.

Rights And Responsibilities Under The UM Program**Your Enrollee Rights**

Under the UM program, you have the right to:

- A UM decision that is timely, meeting applicable state and federal time frames
- The reasons for CBHA's denial of a requested treatment or health care service, including an explanation of the UM criteria and treatment protocol used to reach the decision
- Have a medical director from CBHA make a review of all denials of service that were based upon Medical Necessity
- Request a review of denial of benefit coverage through the Grievance process. See Section Ten, Grievance and Appeal Process
- Have an authorized representative pursue payment of a claim or make an Appeal on your behalf.

An authorized representative may act on the Enrollee's behalf with the Enrollee's written

consent. In the event you appoint an authorized representative, “you” under the “Utilization Management” section mean “you or your authorized representative” (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

CBHA’s Responsibilities

As part of all UM decisions, CBHA will:

- Provide you and your Provider with a toll-free telephone number (**1-800-475-7900**) to call UM review staff whenever Certification of a health care service is needed.
- Limit what CBHA requests from you or your Provider to information that is needed to certify the service in question
- Request all information necessary to make the UM decision, including pertinent clinical information
- Provide you and your Provider prompt notification of the UM decision consistent with the Plan.
- In the event CBHA does not receive sufficient information to certify coverage for a health care service within specified time frames, CBHA will notify you in writing that benefit coverage has been denied. The notice will explain how you may pursue a review of the UM decision.

Prospective Reviews

As part of receiving coverage under the UM process, the Plan requires that Behavioral Health Care Services (except Emergencies) be reviewed before you receive them. These types of reviews are called Prospective Reviews. You may call CBHA Customer Services at **1-800-475-7900** if you have questions regarding services that require Certification in advance. Although no Certification is required for Emergency situations, please notify CBHA of your Inpatient admission as soon as reasonably possible or within 48 hours. See Emergency Care in Section Two Paragraph 3 and Paragraph 4 for more information. CBHA approves or denies the request based on Medical Necessity. If the service is denied refer to Section Ten, Grievances and Appeals.

CBHA will make a decision on your request within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated to you and your Provider within three business days after CBHA receives all necessary information but no later than 15 days from the date CBHA received the request. If your request is incomplete, then within five days from the date CBHA received your request, CBHA will notify you and your Provider of how to properly complete your request. CBHA may also take an extension of up to 15 days if additional information is needed. CBHA will notify you and your Provider before the end of the initial 15-day period of the information needed and the date by which CBHA expects to make a decision. You will have 45 days to provide the requested information. As soon as CBHA receives the requested information, or at the end of the 45 days, whichever is earlier, CBHA will make a decision within three business days. If CBHA does not certify benefit coverage of a health care service, CBHA will notify you and the Provider by written or electronic confirmation.

Expedited Prospective Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your Dependent's life, health, or ability to regain maximum function; or (ii) in the opinion of your Provider, would subject you or your Dependent to severe pain that cannot be adequately managed without the requested care or treatment. CBHA will notify you and your Provider of its decision as soon as possible, taking into account the medical circumstances. CBHA will notify you and your Provider of its decision within 72 hours after receiving the request. If CBHA needs additional information to process your expedited review, CBHA will notify you and your Provider of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as CBHA receives the requested information, or at the end of the time period specified for you to provide the information, whichever is earlier, CBHA will make a decision on your request within a reasonable time but no later than 48 hours. An expedited review may be requested by calling CBHA Customer Services at **1-800-475-7900**.

Concurrent Reviews

CBHA will also review health care services at the time you receive them. These types of reviews are called Concurrent Reviews. CBHA will communicate Concurrent Review decisions to the Hospital or other facility within three business days after CBHA receives all necessary information, but no later than 15 days after the request. If CBHA does not certify benefit coverage of a health care service, CBHA will notify you, your Hospital's or other facility's UM department and your Provider. Written confirmation of the decision will be sent to your home by U.S. mail. For Concurrent Reviews, the Plan will remain responsible for covered services you are receiving until you or your representatives have been notified of the denial of benefit coverage.

Expedited Concurrent Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your Dependent's life, health, or ability to regain maximum function; or (ii) in the opinion of your Provider, would subject you or your Dependent to severe pain that cannot be adequately managed without the requested care or treatment. If you request an extension of treatment that CBHA has already approved at least 24 hours before the current approved treatment ends, CBHA will notify you and your Provider of its decision as soon as possible taking into account the medical circumstances, but no later than 24 hours after receiving the request.

Retrospective Reviews

CBHA also reviews the coverage of health care services after you receive them (called Retrospective Reviews) under special circumstances. Retrospective Review may include a review to determine if services received in an emergency setting qualify as an Emergency. CBHA will make all Retrospective Review decisions and notify you of its decision within a reasonable time but no later than 30 days from the date CBHA received the request. When the decision is to deny benefit coverage, CBHA will notify you and your Provider in writing within five business days of the decision. All decisions will be based on Medical Necessity and whether the service received was a benefit under the Plan. CBHA may take an extension of up to 15 days

if additional information is needed. Before the end of the initial 30-day period, CBHA will notify you of the extension, the information needed, and the date by which CBHA expects to make a decision. You will then have 90 days to provide the requested information. As soon as CBHA receives the requested information, or at the end of the 90 days, whichever is earlier, CBHA will make a decision within 15 days. Services that were certified in advance by CBHA will not be subject to denial for Medical Necessity once the claim is received, **unless the Certification was based on a material misrepresentation about your health condition or you were not eligible for these services under the Plan.** All other services may be subject to Retrospective Review and could be denied for Medical Necessity or for a benefit limitation or exclusion. If Certification for benefit coverage for health care services is denied, you have the right to request that the Plan review the decision through the Grievance process. Refer to Section Ten, Grievances and Appeals for additional information.

SECTION TEN: GRIEVANCE AND APPEAL PROCESS

Note: The following definitions apply to Section Ten “Grievance and Appeal Process”. For general Plan definitions, please refer to Section Thirteen “Definitions”.

A. Appeal means a review of Non-Certification of services based on clinical reasons by Carolina Behavioral Health Alliance.

B. Behavioral Health Care Services means services provided for the diagnosis, prevention, treatment, cure, or relief of a behavioral health condition, illness, injury, or disease.

C. Behavioral Health Quality Improvement and Review Committee means a committee composed of licensed Behavioral Health Care Providers that is formed for the purpose of evaluating the quality of, cost of, or necessity for Behavioral Health Care Services, including Provider credentialing.

D. Clinical Peer means a health care professional that holds an unrestricted license in a state of the United States, in the same or similar specialty, and routinely provides the Behavioral Health Care Services subject to Utilization Review.

E. Clinical Review Criteria means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by us to determine Medically or Psychologically Necessary Services and Supplies.

F. Covered Person means any enrollee covered under this Summary Plan Description. “Covered Person” includes another person, other than the Covered Person’s Provider, who is authorized to act on behalf of a Covered Person.

G. Emergency Mental Health and Substance Abuse Condition means the sudden or unexpected onset of a mental or substance abuse condition requiring immediate mental health or substance abuse treatment which an Enrollee secures after the onset of such condition, and that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention to result in any of the following:

- serious physical impairment or death;
- serious or permanent dysfunction of your mental health; **or**
- your or a third party's health placed in serious jeopardy.

H. Emergency Services means Medically or Psychologically Necessary Services furnished or required to screen for or treat an Emergency Mental Health or Substance Abuse Condition until the condition is Stabilized.

I. Grievance means a written complaint submitted by an Enrollee, Provider or representative acting on behalf of the Enrollee about any of the following:

- our decisions, policies, or actions related to availability, delivery, or quality of Behavioral Health Care Services;
- claims payment or handling; or reimbursement for services;
- the Contractual relationship between a Covered Person and Wake Forest University; or
- the outcome of an Appeal of a Non-Certification under this section.

J. Health Benefit Plan means the comprehensive Behavioral Health Care Services provided or arranged by Wake Forest University

K. Medically or Psychologically Necessary Services means those Covered Behavioral Health Services:

- ♦ Necessary and appropriate for the diagnosis, evaluation or treatment of a mental health or substance abuse (chemical dependency) condition or illness other than mental disability with a distinct DSM diagnosis;
- ♦ Reasonably expected to improve the individuals condition or level of functioning or at least prevent further deterioration;
- ♦ Provided at a level of care appropriate to the severity of the patient's illness and capacity to respond to professionally provided treatment;
- ♦ Consistent with generally accepted standards of mental Health Professional practice (psychiatry, clinical psychology, clinical social work) in the community;
- ♦ Within the professional competence of the Provider;
- ♦ Not for experimental, investigational or cosmetic purposes; and

- ♦ Not solely for the convenience of you, your family or the Provider.

L. Non-Certification means a determination by us or our designated Utilization Review Organization that an admission, availability of care, continued stay, or other Behavioral Health Care Service has been reviewed and, based upon the information provided, does not meet our requirements for Medical or Psychological Necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated. A Non-Certification is not a decision rendered solely on the basis that the Plan does not provide Benefits for the Behavioral Health Care Service in question, if the exclusion of the specific service requested is clearly stated in this Summary Plan Description.

M. Participating Provider means a Provider who, under Contract with CBHA (the Behavioral Health Plan Administrator), has agreed to provide Behavioral Health Care Services to Covered Persons in return for direct or indirect payment from Wake Forest University, other than Coinsurance, Co-payments, or Deductibles.

N. Provider means a Behavioral Health Care Provider- any person who is licensed, registered, or certified under Chapter 90 of the General Statutes; a health care Facility as defined in G.S. 131E-176(9b).

O. Stabilize means to provide Behavioral Health Care that is appropriate to prevent a material deterioration of your condition, within reasonable medical probability, in accordance with HCFA (Health Care Financing Administration) interpretative guidelines, policies, and regulations pertaining to responsibilities of Facilities in emergency cases, including Medically or Psychologically Necessary Services and Supplies to maintain Stabilization until you are transferred. This definition also applies to the term as it is used in Section Two.

P. Utilization Review “UR” means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of Behavioral Health Care Services, procedures. These techniques may include:

- 1) **Ambulatory Review** which is Utilization Review of services performed **or** provided in an outpatient setting.
- 2) **Case Management** which is a coordinated set of activities conducted for individual Enrollee management of serious, complicated, protracted, or other health conditions.
- 3) **Certification** which is a determination by us or our designated URO that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, **satisfies** our requirement for Medically or Psychologically Necessary Services and Supplies, appropriateness, health care setting, level of care, and effectiveness.
- 4) **Concurrent Review** which is Utilization Review conducted during your Facility stay or course of treatment.

5) Discharge Planning which is the formal process for determining, before discharge from a Provider Facility, the coordination and management of the care that you receive after discharge from a Provider Facility.

6) Prospective Review which is Utilization Review conducted before an admission or a course of treatment including any required preauthorization or precertification.

7) Retrospective Review which is Utilization Review of Medically or Psychologically Necessary Services or Supplies that is conducted after services or supplies have been provided to you, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

8) Second Opinion which is an opportunity or requirement to obtain a clinical evaluation by a Provider other than the Provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

9) Utilization Review Organization or “URO” means an entity that conducts Utilization Review under a managed care Plan, but does not mean our performing Utilization Review for our own Health Benefit Plan.

Grievance Process

In addition to the UM program, the Plan offers a Grievance procedure for Enrollees. Grievances include dissatisfaction with a claims denial or any decisions (including an Appeal of a Non-Certification decision), policies or actions related to the availability, delivery or quality of health care services. If you have a Grievance, you have the right to request that CBHA review the decision through the Grievance process.

The Grievance process is voluntary and may be requested by the Enrollee or an authorized representative acting on the Enrollee’s behalf with the Enrollee’s written consent. In the event you appoint an authorized representative, references to “you” under this section mean “you or your authorized representative” (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations). For each step in this process, there are specified time frames for filing a Grievance and for notifying you or your Provider of the decision.

Wake Forest University Health Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Steps To Follow In The Grievance Process

The review should be requested in writing, within 180 days of a denial of benefit coverage.

Any request for review should include:

- Enrollee’s ID number
- Enrollee’s name
- The nature of the Grievance
- Any other information that may be helpful for the review.

Within three business days after receipt of a review request, CBHA will provide you with the name, address and phone number of the Grievance coordinator. CBHA will also give you instructions on how to submit written materials. For Grievances concerning quality of health care, an acknowledgement will be sent by CBHA within ten business days.

CBHA asks that you send all of the written material you feel is necessary to make a decision. CBHA will use the material provided in the request for review, along with other available information, to reach a decision. You will be notified in clear written terms of the decision within a reasonable time but no later than 30 days from the date CBHA received the request. Any Grievance relating to a Non-Certification determination made by CBHA relative to an admission, availability of care, continued stay or other behavioral health service that had been reviewed and denied, reduced or terminated based upon CBHA's requirements for:

- Medical necessity
- Appropriateness
- Health care setting
- Level of care or effectiveness

are reviewed by the CBHA Medical Director or Assistant Medical Director (psychiatrists licensed by the state of North Carolina). The Medical Director or Assistant Medical Director who conducts the review shall not have been involved with the initial Non-Certification decision. Details of this process are outlined below in the "Appeals Review Process" section.

If the decision is **not** in favor of the Enrollee, the written decision shall include the following:

- The professional qualifications and licensure of the person(s) conducting the Grievance review;
- A statement of the reviewer's understanding of what is being Appealed
- The reviewer's decision/resolution in clear terms, stating the Contractual or medical rationale for the decision in sufficient detail for the Enrollee, representative, or Provider to respond further, if desired;
- A reference to the evidence and documentation used as a basis for the decision/resolution, including the Clinical Review Criteria used to make the determination and instructions for requesting a written copy of the criteria; and,
- A statement advising the complainant of any voluntary dispute resolutions options available, such as mediation, and to contact the local U.S. Department of Labor Office or State insurance regulatory agency for further information.

Appeals Review Process

Outlined below are steps the member or member's representative can take to appeal a decision of non-certification of services:

A. An enrollee, representative or provider may submit a formal written appeal to CBHA within one hundred eighty (180) days of a non-certification; additional clinical information may be submitted, if available.

B. All written appeals are to be forwarded to the QI Manager for logging into the QI tracking system.

C. An acknowledgement letter is sent to the appealing individual/facility within three (3) business days of receipt of the appeal. This letter includes the name, address and phone number of the appeals coordinator and provides instructions for submitting written material.

CBHA has thirty (30) days to review the appeal and prepare a written decision concerning the appeal. The QI Manager is responsible to coordinate the appeal review and develop the response to the enrollee and/or representative or provider.

Reviews are conducted by the CBHA Medical Director or Assistant Medical Director(s) who are medical doctors (psychiatrists) licensed by the State of North Carolina. The Medical Director or Assistant Medical Director who conducts the review shall not have been involved with the initial non-certification decision.

If the decision is not in favor of the enrollee, the written decision shall include the following:

- The professional qualifications and licensure of the person(s) conducting the appeal review;
- A statement of the reviewer's understanding of what is being appealed;
- The reviewer's decision/resolution in clear terms, stating the contractual or medical rationale for the decision in sufficient detail for the enrollee, representative or provider to respond further, if desired;
- A reference to the evidence and documentation used as a basis for the decision/resolution, including the clinical review criteria used to make the determination and instructions for requesting a written copy of the criteria; and,
- A statement advising the complainant there may be voluntary dispute resolution options available, such as mediation, and to contact the local U.S. Department of Labor Office or State insurance regulatory agency for further information.

Second Level Appeal Process

If you receive a denial for further coverage on an initial appeal of non-certified care, you may be request a second level of appeal. Since the Plan is subject to **ERISA**, the first level appeal review is the only level that you must complete before you can pursue your appeal in an action in federal court. In order to file a second level appeal, you will need to send supporting documentation to : CBHA, PO Box 571137, Winston-Salem, NC 27157-1137 ATTN: Quality Improvement Manager. Once CBHA has received your information, you can expect the following to occur:

- A. CBHA will send an acknowledgement letter to you, your representative or provider within three (3) business days of receipt of the appeal. This letter includes the name, address and phone number of the appeals coordinator and provides instructions for submitting written material.
- B. Once CBHA has received all of the necessary material, a review will be conducted by an appropriate mental health professional that was not involved in the initial non-certification decision or the adverse first level of appeal decision

- C. If the decision is not in favor of the enrollee, the written decision shall include the following:
- The professional qualifications and licensure of the person(s) conducting the appeal review;
 - A statement of the reviewer's understanding of what is being appealed;
 - The reviewer's decision/resolution in clear terms, stating the medical rationale for the decision in sufficient detail for the enrollee, representative or provider to respond further, if desired;
 - A reference to the evidence and documentation used as a basis for the decision/resolution, including the clinical review criteria used to make the determination and instructions for requesting a written copy of the criteria; and,
 - If eligible and applicable, the enrollee will be informed of any options to further dispute the appeal directly with their employer;
 - A statement advising the claimant there may be voluntary dispute resolution options available, such as mediation, and to contact the local U.S. Department of Labor Office or State insurance regulatory agency for further information.
- D. CBHA will provide a response within 30 days of the initial request for any pre-service denial.

The second level appeal must be filed within 45 days of receipt of the first level appeal decision.

Expedited Appeal Process

An expedited appeal of non-certification may be requested by an enrollee, representative or a provider acting on the enrollee's behalf when a non-expedited appeal would reasonably appear to seriously jeopardize an enrollee's life, health or ability to regain maximum function. Medical documentation may be required to justify the appeal. A written decision is to be delivered to the enrollee no later than 72 hours after receiving information to justify the expedited appeal.

In the event there is insufficient information to make a determination, CBHA shall request additional information and allow the insured at least 48 hours to provide additional information and shall issue a determination within 48 hours of receiving the additional information or within 48 hours of the expiration of the time allowed the insured to submit the information, whichever is sooner.

Expedited appeals are conducted by the CBHA Medical Director or Assistant Medical Director(s) who are medical doctors (psychiatrists) licensed by the State of North Carolina. The Medical Director/Assistant Medical Director conducting the expedited appeal shall not have been involved with the initial non-certification. A decision shall be rendered as soon as possible, but not later than 72 hours after receiving the information justifying the expedited appeal.

The QI Manager is responsible to send a written decision to the enrollee within the 72 hour time frame. If the decision is not in favor of the enrollee, the written decision shall include the following:

- The professional qualifications and licensure of the person(s) conducting the appeal review;
- A statement of the reviewer's understanding of what is being appealed;
- The reviewer's decision/resolution in clear terms, stating the contractual or medical rationale for the decision in sufficient detail for the enrollee/provider to respond further, if desired;
- A reference to the evidence and documentation used as a basis for the decision/resolution, including the clinical review criteria used to make the determination and instructions for requesting a written copy of the criteria;
- A statement advising the complainant there may be voluntary dispute resolution options available, such as mediation, and to contact the local U.S. Department of Labor Office or State insurance regulatory agency for further information.

In situations where the expedited review is a concurrent review, CBHA remains liable for the coverage of behavioral health services until the enrollee has been notified of the determination. CBHA is not required to provide an expedited review for retrospective non-certifications.

External Review

Federal law provides for an external review of an *adverse benefit determination* by an external, independent review organization (IRO). This service is administered by the *Plan* at no charge to you. The *Plan* will notify you of your right to request an external review each time you receive:

- an *adverse benefit determination*
- an *appeal decision upholding an adverse benefit determination*, or
- a *final internal adverse benefit determination*

In order to request an external review, CBHA must receive your request within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. You are not eligible to request an external review until the internal appeals process has been completed and a final adverse benefit determination has been issued by the Plan. You have exhausted the Plan's internal appeal process once you have gone through the first level appeal process. While a second level appeal process is available to you, the process is completely voluntary and not required prior to requesting an external review. To request an external appeal, send your request to the following:

CBHA
PO Box 571137
Winston-Salem, NC 27157
ATTN: Quality Improvement

Expedited External Review - An expedited external review may be available if (1) the time required to complete either an expedited internal appeals review or a standard external review would reasonably be expected to jeopardize your life or health or ability to regain maximum function, or (2) the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility. If your request is not accepted for expedited review, the *Plan* may: (1) accept the case for standard external review if the

internal appeals process has been exhausted; or (2) require the completion of the internal appeals process and another request for an external review.

Within five (5) business days of (or, for an expedited review, immediately upon) receiving your request for an external review, the *Plan* must determine whether the external review is eligible (“preliminary review”). The request is eligible if it meets the following requirements:

- You are or were covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the *Plan* at the time the health care item or service was provided;
- The *adverse benefit determination* or the final *adverse benefit determination* does not relate to your failure to meet the requirements for eligibility under the terms of the *Plan* (e.g., worker classification or similar determination);
- You have exhausted the *Plan*’s internal appeal process unless you are not required to exhaust the internal appeals process; and
- You provided all the information and forms required to process an external review.

Within one (1) business day of (or, for expedited review, immediately upon) completing the preliminary review, the *Plan* will notify you in writing of whether your request is complete and whether it has been accepted. If the *Plan* notifies you that the request is incomplete, you must provide all requested information to the *Plan* within the four (4) month filing period or within 48 hours following the receipt of the notice, whichever is later. If the *Plan* accepts your request, the assigned IRO will timely notify you in writing of the acceptance of the external review. The notice will include a notification that you may submit additional written information and supporting documentation relevant to the *adverse benefit determination* to the assigned IRO within ten (10) business days following the date of receipt of the notice. Within five (5) business days (for an expedited review, as expeditiously as possible) after the date of assignment of the IRO, the *Plan* shall provide the IRO the documents and any information considered in making the *adverse benefit determination*.

The IRO will send you and the *Plan* written notice of its decision within 45 days. If the request is expedited, the IRO will notify you and *Plan* as expeditiously as possible, but in no event more than 72 hours after the IRO receives the request. If the notice is not in writing, the IRO shall provide written confirmation to you and the *Plan* within 48 hours after the date of providing the notice. If the IRO’s decision is to reverse the *adverse benefit determination*, the *Plan* will immediately provide coverage or payment for the requested services or supplies. If you are no longer covered by the *Plan* at the time the *Plan* receives notice of the IRO’s decision to reverse the *adverse benefit determination*, the *Plan* will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been denied when first requested. The IRO’s external review decision is binding on you and the *Plan*, except to the extent you may have other remedies available under applicable federal law. You may not file a subsequent request for an external review involving the same *adverse benefit determination*, for which you have already received an external review decision.

PLEASE CALL CAROLINA BEHAVIORAL HEALTH ALLIANCE at 1-800-475-7900 IF YOU HAVE ANY QUESTIONS ABOUT THE GRIEVANCE AND APPEAL PROCEDURES.

SECTION ELEVEN: ERISA RIGHTS**Summary *Plan* Description**

The following information, together with the information contained in the benefit booklet furnished to *employees* by the *Plan Administrator*, is intended to furnish the Summary *Plan* Description required by Section 102 of the Employee Retirement Income Security Act of 1974 (*ERISA*):

Name and Number of *Plan(s)*

Plan Number 501 - Group Health Plan for *employees* of Wake Forest University Health and Welfare Benefit Plan

Name, Address and Telephone Number of *Plan Sponsor*

Wake Forest University Health and Welfare Benefit Plan
1834 Wake Forest Road
Winston-Salem, NC 27106
336-758-5241

Other *Employers* Adopting the *Plan(s)*

Reynolda House Museum of American Art

Employer Identification Number of Plan Sponsor

56-0532138

Identification of *Plan Administrator*

Wake Forest University
1834 Wake Forest Road
Winston-Salem, NC 27106

Identification of *Claims Administrator*

Carolina Behavioral Health Alliance
PO Box 571137
Winston-Salem, NC 27157-1137

ERISA Rights Statement

As a participant in the Wake Forest University's benefit Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Enrollees shall be entitled to:

Examine, without charge, at the Wake Forest University office and at other specified locations, such as worksites, all Plan documents, including insurance Contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

Obtain, upon written request to the Wake Forest University, copies of documents governing the operation of the Plan, including insurance Contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions. Wake Forest University may make a reasonable charge for the copies.

Receive a summary of the Plan's financial report. Wake Forest University is required by law to furnish each Enrollee with a copy of this summary annual report.

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for *pre-existing conditions* under your group's health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from BCBSNC or the *Plan Administrator* when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to *pre-existing conditions* exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Enrollees and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court

may require Wake Forest University to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Wake Forest University. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact Wake Forest University. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION TWELVE: GENERAL PROVISIONS

- 1. No Assignment.** You may not assign any Benefits or money due under this Summary Plan Description to, any person, corporation, organization or other entity. Any assignments by you will be void and have no effect. Assignment means the transfer to another person, corporation, organization or other entity of your right to the Benefits provided under this Summary Plan Description.
- 2. Notice.** Any notice that we give to you will be in writing and mailed to you at the address as it appears on our records, when permitted by law. If you have to give us any notice, it should be in writing and mailed to our offices at:

Wake Forest University
Human Resources Office
P.O. Box 7424
Winston-Salem, NC 27109

If we change our address, we will notify you in writing.

- 3. Authorization to Obtain and Release Information.** Your signature obtained during the enrollment process, on a claim form or in a Provider's medical or psychological records serves as authority to release medical or psychological records to the Behavioral Health Plan.

Administrator (CBHA). We have the right to release or obtain medical or psychological records and related information necessary to process your claim for Benefits. By enrolling in the Wake Forest University Plan, you have agreed to furnish to us any information requested to process your claim. If you do not provide the information to us, we have the right to deny payment of your claim.

4. **Notice of Claim.** For us to make payment under this program, we must receive your claim for Benefits within twelve (12) months after you receive the service. Notice given by or on behalf of you to Wake Forest University at the address in Paragraph 2 above, or to any authorized agent of Wake Forest University, with information sufficient to identify the insured, shall be deemed notice to Wake Forest University. Failure to furnish proof of loss within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the event of legal incapacity, later than twelve months from the time proof is otherwise required.
5. **Who Receives Payment under this Summary Plan Description.** We will make payments under this Summary Plan Description for services of a Network Facility or Network Provider directly to the Facility, or Provider.
6. **Recovery of Overpayments.** On occasion, we may pay you when you do not have coverage, or pay a service that is not covered, or overpay a service. When this happens, we will explain the problem to you and you must return to us within sixty (60) days the amount of the mistaken payment. Or, you must provide us with written notice stating the reasons why you may be entitled to such payment. On the basis of applicable law, we may reduce our future payments to you to recover any mistaken payment. Overpayments and mistaken payments we make to Providers will be recovered directly from them.
7. **Time to Bring Legal Action.** You must begin any lawsuit against Wake Forest University under this Summary Plan Description within three (3) years from the date a claim is required to be submitted by you or your Provider.
8. **Limitation on Benefits of this Summary Plan Description.** No person or entity other than Wake Forest University and you shall bring any action to enforce any part of this Summary Plan Description against Wake Forest University or you. The agreements in this Summary Plan Description shall be solely for the benefit of, and enforceable only by, Wake Forest University and the covered Enrollees.
9. **Applicable Law.** This Summary Plan Description, the rights and obligations of Wake Forest University and the Enrollees under this Summary Plan Description, and any related claims or disputes, shall be governed by federal law.
10. **Headings.** Section and subsection headings in this Summary Plan Description are inserted for convenience of reference only. Headings shall not be deemed to be part of this Summary Plan Description for any purpose. They shall not in any way define or affect the meaning or scope of any of the provisions.

- 11. Pronouns.** All pronouns and any variations shall refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.
- 12. Severability.** If any part of this Summary Plan Description or any other document used in connection with this Summary Plan Description shall be found invalid or unenforceable under law, only such part shall be invalid. This shall not affect the remaining parts of this Summary Plan Description or such other document.
- 13. Waiver.** The waiver or failure to enforce rights by any party of any part of this Summary Plan Description shall not be a Waiver of any other parts or rights.
- 14. Administrative Discretion-**CBHA has the authority to make reasonable determinations in the administration of coverage. These determinations will be final. Such determinations include decisions concerning coverage of services, care, treatment or supplies, and reasonableness of charges. CBHA medical necessity policies are guides considered when making coverage determinations.
- 15. Programs Outside Your Regular Benefits-** The *Plan Administrator* and CBHA may add programs that are outside your regular benefits. These programs may be changed from time to time. Following are examples of programs that may be included outside your regular benefits:
- Service programs for members identified with complex health care needs, including a dedicated administrative contact, consolidated claims data information, and supportive gift items
 - Wellness programs, including discounts on goods and services from other companies including certain types of *providers*
 - Clinical Opportunities Notification Program involves the analysis of claims and subsequent notification to *providers* suggesting consideration of certain patient-specific treatment options along with medical literature addressing these treatment options

These discounts on goods and services may not be provided directly by the *Plan* or CBHA, but may instead be arranged for your convenience. These discounts are outside the *Plan* benefits. Neither the *Plan* nor CBHA is liable for problems resulting from goods and services it does not provide directly, such as goods and services not being provided or being provided negligently. The gifts and charitable donations are also outside the *Plan* benefits. Neither the *Plan* nor CBHA is liable for third party *providers'* negligent provision of the gifts. The *Plan Administrator* may stop or change these programs at any time.

- 16. Health Information Services-** If you have certain health conditions, CBHA or a representative of CBHA may contact you to provide information about your condition, answer questions and tell you about resources that may be available to you. Your participation is voluntary, and your medical information will be kept confidential.
- 17. WFU Administrative Authority-** As a self-funded plan, Wake Forest University retains administrative discretion of the plan, as well as the right to amend or terminate the Plan.

Wake Forest University. Wake Forest will provide 60 days notice to enrollees prior to any changes in the plan that would alter Enrollees' benefits for Covered Behavioral Health Services.

- 18. Administration of the Plan** – Wake Forest University is the Plan Sponsor and Plan Administrator for this Plan. The Plan Administrator shall have full charge of the operation and management of the Plan. All matters relating to the administration of the Plan, including the duties imposed upon the Plan Administrator by law and the interpretation of the Plan provisions are the responsibility of the Plan Administrator. In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. The Plan Administrator has the authority, in the Plan Administrator's sole discretion, to interpret the Plan and resolve ambiguities therein, to develop rules and regulations to carry out the provisions of the Plan, and to make factual determinations. However, the Plan Administrator shall have the right to hire all persons providing services to the plan, for example; Wake Forest University has appointed a Claims Administrator to receive, review and process claims for behavioral health benefits. Carolina Behavioral Health Alliance is the Claims Administrator for behavioral health benefits.

The Plan Administrator has delegated to Claims Administrator its entire discretionary authority to determine eligibility for benefits and the amount of benefits due, to construe the terms of the contract, and generally to do all other things needed to administer the contract. The Plan Administrator retains all of its other authority.

- 19. Amendment And/Or Termination Of The Plan** - The Plan Sponsor, Wake Forest University, expects this Plan to be continued indefinitely, but reserves the right to terminate the Plan at any time with respect to its employees by a written instrument signed by the Plan Administrator. Such termination may be made without the consent of the members, or any other persons. The Plan Administrator also reserves the right to amend the Plan, including reduction or elimination of benefits or covered services. Amendments shall be made only in accordance with the provisions of the Plan. The Plan Administrator will provide notice to members within sixty days of the adoption of any amendment that results in a material reduction in covered services or benefits.

SECTION THIRTEEN: DEFINITIONS

Throughout this Summary Plan Description, Wake Forest University is referred to as "Wake Forest University," "we," "us," or "our." The words "you," "your," and "yours" refer to you, the person to whom this Summary Plan Description is issued. It also refers to the Summary Plan Description Holder's covered spouse and covered Dependents, collectively the Enrollees. The capitalized words or terms used in this Summary Plan Description that are not otherwise defined have the meanings set forth below:

- 1. Annual Enrollment** means an enrollment period of time no shorter than ten (10) business days that is held each year as determined by the Group. Refer to Section One, “Who is Covered” for eligibility rules.
- 2. Behavioral Health Care Services** means services provided for the diagnosis, treatment, cure, or relief of a behavioral health condition, illness, injury, or disease.
- 3. Benefits** means payments for health care for the Enrollees under the Wake Forest University program.
- 4. Benefit Year** means the calendar year, or other twelve (12) month period designated by your Group for the calculation of Deductibles, Coinsurance and certain other qualifying Out-of-Pocket expenses as stated in the Enrollee Summary Plan Description. The accumulation is used to determine the total Out-of-Pocket expenses Incurred by the Enrollee. The benefit year for this Summary Plan Description is January-December.
- 5. Claims Administrator** means Carolina Behavioral Health Alliance.
- 6. Coinsurance** means a fixed percentage of charges you must pay toward the cost of Covered Behavioral Health Services. The percentage is based on the lesser of the allowable charges or the Maximum Allowable Payment.
- 7. Contract** means the Contract issued by Wake Forest University. It includes the Contract, Group Application Form, Enrollee Summary Plan Description, Summary of Benefits, and all attachments, endorsements, riders, applications and amendments.
- 8. Contract Period** means each twelve consecutive month period ending on the anniversary date during which the Contract is in effect. However, the first Contract Period may be less than a twelve-month period, depending on the Effective Date, as specified in the Group Application.
- 9. Co-payment** means a fixed dollar amount that you must pay each time you receive a particular Covered Service.
- 10. Covered Behavioral Health Services** means Medically or Psychologically Necessary Services for which we will make payments under this Summary Plan Description. Covered Behavioral Health Services do not include services and care excluded in Section Four or which do not meet the definition of “Medically or Psychologically Necessary” in this Section and the other qualifications set forth in Section Three.
- 11. Creditable Coverage** means, with respect to an individual, coverage of the individual under a) a self-funded employer Group health Plan under the Employee Retirement Income Security Act of 1974; b) Group or individual health coverage; c) Part A or B of Title XVIII of the Social Security Act; d) Title XIX of the Social Security Act, other than coverage consisting solely of Benefits under Section 1928; e) Chapter 55 of Title 10, United States Code; f) a medical care program of the Indian Health Service or of a tribal organization; g) a State health Benefits risk

pool; h) a health Plan offered under Chapter 89 of Title 5, United States Code; i) a public health Plan (as defined in the federal regulations; j) a Health Benefit Plan under section 5(e) of the Peace Corps Act. Creditable Coverage does not include coverage consisting solely of coverage of excepted Benefits.

12. Dependent means any person in an Enrollee's family who meets the requirements of Section One "Who is Covered" of the Summary Plan Description.

13. Dependent Child(ren) A child under age 26 who is the *employee's* biological child, a stepchild who lives with the *employee*, a legally adopted child (or child placed with the *member* and/or spouse for adoption), a *foster child*, or any other child for whom legal guardianship has been awarded to *employee* and/or spouse.

14. Deductible means a fixed dollar amount that you must incur before we begin to pay for the cost of Covered Behavioral Health Services provided to you during each Benefit Year. Please refer to your Summary of Benefits to see if any services require the payment of a Deductible.

15. Effective Date means the beginning date of this Contract as described in the Group Application-July 1, 2011.

16. Emergency Mental Health and Substance Abuse Condition means the sudden or unexpected onset of a mental or substance abuse condition requiring immediate mental health or substance abuse treatment which you secure after the onset of such condition, and that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention to result in any of the following:

- serious physical impairment or death;
- serious or permanent dysfunction of your mental health; or
- your or a third party's health placed in serious jeopardy.

17. Emergency Services means Medically or Psychologically Necessary Services furnished or required to screen for or treat an Emergency Mental Health or Substance Abuse Condition until the condition is Stabilized.

18. Emergency Room means a unit or department of an acute care general Facility which is used specifically to treat a life-threatening Illness or injury.

19. Employee means an Employee, member, partner, Board member, associate or other participant in the Group who meets all applicable eligibility requirements of the Group Application as determined by the Wake Forest University. Retirees under age 65, as defined in the Policy of Wake Forest University, are eligible for benefits under the plan.

20. Enrollee means a covered employee under this Summary Plan Description, the spouse of the covered employee under Summary Plan Description, or the Dependents of the covered employee under this Summary Plan Description.

21. Enrollee Coverage Summary Plan Description means the Summary Plan Description issued by Wake Forest University to Enrollees, including any and all applications, attachments, endorsements, riders and amendments.

22. Enrollment Application means the form to be completed by prospective enrollees under this Summary Plan Description when they apply for enrollment under the Wake Forest University. You may obtain an Enrollment Application from Wake Forest University.

23. “ERISA” shall mean the Employee Retirement Income Security Act of 1974 (including amendments of the Code effected thereby), and rules and regulations promulgated thereunder.

24. Group means Wake Forest University, which arranges for your coverage described in this Summary Plan Description.

25. Health Professionals means physicians, nurses, clinical psychologists, and other professionals, who engage in the delivery of Behavioral Health Care Services. These Health Professionals who:

- Are licensed;
- Practice under an institutional license;
- Are certified; and
- Practice under the authority of a Physician or a legally constituted professional association, or other recognized and accepted authority;
- must have the ability to demonstrate current competence;
- continuously meets and satisfies the regulatory qualifications, standards and requirements necessary to practice in their service location;
- possesses physical and mental health to provide quality Behavioral Health Care Services.

26. Hospital means an institution that:

- Is licensed as a Hospital by the state authorities, is operated according to law and is primarily engaged in providing, on an inpatient and outpatient basis, for the medical care and treatment of sick and injured persons through medical, diagnostic, emergency and major surgical facilities—all of these services must be provided on its premises under the supervision of a staff Physician and with twenty-four (24) hours-a-day nursing service;
- May not meet all of the above requirements, but is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals (JCAHO) or another nationally recognized accrediting body;
- Is not primarily a place for rest or custodial care of the aged; and
- Is not a nursing home.

27. Incurred means those services and supplies rendered to a Covered Person. Such expenses shall be considered to have occurred at the time or date the service or supply was actually purchased or provided.

28. Out-of-Pocket Maximum means the maximum amount you must pay in Deductible, Co-payments and Coinsurance in a given year before your Benefits are paid in full. Your Out-of-Pocket Maximum Limitation is listed on your Summary of Benefits.

29. Maximum Allowable Payment (or Allowed Amount) The maximum amount that CBHA determines is reasonable for *covered services* provided to a *member*. For *providers* that have entered into an agreement with CBHA, the allowed amount is the negotiated amount that the *provider* has agreed to accept as payment in full. Except as otherwise specified in “Emergency Services” and “Emergency Admissions”, for *providers* that have not entered into an agreement with CBHA, the allowed amount will be the lesser of the *provider’s* billed charge or an amount based on the fee schedule established by CBHA that is applied to comparable *providers in the CBHA geographic service area* for similar services under a similar health benefit plan. Where CBHA has not established a fee schedule amount for the billed service, the allowed amount will be the lesser of the *provider’s* billed charge or a charge established by CBHA in negotiations with the providers. Calculation of the allowed amount is based on several factors including CBHA clinical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the *provider* may be combined into one procedure for reimbursement purposes.

30. Medically or Psychologically Necessary Services or Supplies means those Covered Behavioral Health Services or Supplies that:

- Necessary and appropriate for the diagnosis, evaluation or treatment of a mental health or substance abuse (chemical dependency) condition or illness other than mental disability with a distinct DSM-IV diagnosis;
- Reasonably expected to improve the individuals condition or level of functioning or at least prevent further deterioration;
- Provided at a level of care appropriate to the severity of the patient’s illness and capacity to respond to professionally provided treatment;
- Consistent with generally accepted standards of mental Health Professional practice (psychiatry, clinical psychology, clinical social work) in the community;
- Within the professional competence of the Provider;
- Not for experimental, investigational or cosmetic purposes; and
- Not solely for the convenience of you, your family or the Provider.

31. Network Facility means a licensed or accredited acute care Hospital, or other licensed or accredited Facility that provides mental health and/or substance abuse services which has entered into an agreement with CBHA to make available Facility services covered under the Plan.

32. Network Professional means a duly licensed psychiatrist. Licensed clinical psychologist, licensed social worker, licensed professional counselor or other designated mental health Provider who provides or arranges for the provision of Covered Behavioral Health Services in connection with a service Agreement with CBHA, Network Professionals are also referred to as Network Providers.

33. Network Provider means a Network Professional, Network Facility, or other Provider, who has entered into an agreement with Carolina Behavioral Health Alliance, LLC to make Covered Behavioral Health Services available to Enrollees.

34. Out-of-Network Facility or Provider means a Facility or other Provider who does not have an agreement with CBHA to provide Covered Behavioral Health Services to Enrollees.

35. Out-of-Network Service means a Covered Service provided to an Enrollee by an Out-of-Network Facility or Provider.

36. Plan means the Behavioral Health Care Services provided or arranged by Wake Forest University.

37. Plan Administrator means Wake Forest University.

38. Plan Sponsor means Wake Forest University.

39. Provider means a Physician or other Health Professional or Hospital, or other health care Facility or organization providing Behavioral Health Care Services.

40. Referral or Refer means a specific recommendation by a Network Provider that an Enrollee seek additional evaluation or treatment from a specific Provider. The Network Provider is required to notify CBHA to certification of a “Referral.” A general statement by a Network Provider that a patient should seek a particular type of service or Provider does not create a “Referral” under this Summary Plan Description.

41. Service Area means a geographic area in North Carolina that Wake Forest University enrolls persons who work in the Service Area, reside in the Service Area, or work and reside in the Service Area.

42. Stabilize means to provide Behavioral Health Care that is appropriate to prevent a material deterioration of your condition, within reasonable medical probability, in accordance with HCFA (Health Care Financing Administration) interpretative guidelines, policies, and regulations pertaining to responsibilities of Facilities in emergency cases, including Medically or Psychologically Necessary Services and Supplies to maintain Stabilization until you are transferred.

43. Utilization Review “UR” means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of Behavioral Health Care Services, procedures.

SUMMARY OF BENEFITS

This section provides a summary of your mental health and substance use disorder benefits. A more complete description of your benefits is found in “Covered Services.” General exclusions apply see section “Mental Health and Substance Abuse Exclusions.” As you review the “Summary of Benefits” chart, keep in mind:

- Services subject to a Co-payment are not subject to Deductible and Coinsurance but do count towards out of pocket maximums
- Co-payment amounts are fixed dollar amounts the Enrollee must pay for some Covered Services
- Multiple office visits or emergency room visits on the same day may result in multiple Co-payments
- Coinsurance percentages shown in this section are the portion of the Allowed Amount that the Plan covers
- Deductible and Coinsurance amounts are based on Allowed Amount
- Services applied to the Deductible also count toward any visit or day maximums
- To receive In-Network benefits, you must receive care from a CBHA In-Network Provider. However, in an Emergency, or when In-Network Providers are not reasonably available as determined by CBHA's access to care standards, you may also receive In-Network benefits for care from an Out-Of-Network Provider. Please see "Out-Of-Network Benefits" and "Emergency Services" for additional information. Access to care standards are available on the CBHA Web site at www.cbhallc.com or by calling CBHA customer service number at 800-475-7900.
- If you see an Out-Of-Network Provider, you will receive Out-Of-Network benefits unless otherwise approved by CBHA.

SPECIAL NOTICE IF YOU CHOOSE AN OUT-OF-NETWORK PROVIDER

NOTICE: Your actual expenses for Covered Services may exceed the stated Coinsurance percentage or Co-payment amount because actual Provider charges may not be used to determine the Plan's and Enrollee's payment obligations. For Out-Of-Network benefits, you may be required to pay for charges over the Allowed Amount, in addition to a Co-payment or Coinsurance amount. For this plan, the Allowed Amount is determined by the fee schedule that Carolina Behavioral Health Alliance has negotiated with similar network providers in the area services are rendered. If no fee schedule has been negotiated pertinent to the area serviced, the allowable is the lesser of billed charges or a negotiated single case contract.

Benefit payments are based on where services are received and how services are billed.

HIGH PLAN

	In-Network	Out-of-Network
<u>Outpatient Office Visits</u>		
Office Services	\$25 co-pay	70% of the CBHA allowed amount
ABA/ABT Services	\$25 co-pay	70% of CBHA allowed amount
<u>Inpatient Hospital Services</u>		
Hospital and hospital based (includes residential, partial hospital and Intensive Outpatient Programs)	100%	70% of the CBHA allowed amount
Physician Services	100%	70% of the CBHA allowed amount
Emergency Room Visits	\$200 co-pay	\$200 co-pay
	In-Network	Out-of-Network

Lifetime Maximum, Deductible, and Out-of-pocket Maximum

The following deductibles and maximums apply to the services listed above in the “Summary of Benefits” unless otherwise noted.

Lifetime Maximums: None.

Annual Maximums:

ABA/ABT services for autism spectrum disorder	\$40,000	\$40,000
---	----------	----------

Deductible

Individual, per calendar year	None	None
Family, per calendar year	None	None

Out-of-pocket Maximum

Individual, per calendar year	\$1,000	1,000
-------------------------------	---------	-------

Charges for the following do not apply to the Benefit Period **Out-of-pocket Maximum**

- Penalties for non-precertification or utilizing non-network providers
- **Out-of-pocket Maximums** are separate from the medical coverage **Out-of-pocket Maximums**.

LOW Plan

	In-Network	Out-of-Network
<u>Outpatient Office Visits</u>		
Office Services	\$25 co-pay	60% of the CBHA allowed amount
ABA/ABT Services	\$25 co-pay	60% of CBHA allowed amount
<u>Inpatient Hospital Services</u>		
Hospital and hospital based (includes residential, partial hospital and Intensive Outpatient Programs)	100%	60% of the CBHA allowed amount
Physician Services	100%	60% of the CBHA allowed amount
Emergency Room Visits	\$200 co-pay	\$200 co-pay
	In-Network	Out-of-Network

Lifetime Maximum, Deductible, and Out-of-pocket Maximum

The following deductibles and maximums apply to the services listed above in the “Summary of Benefits” unless otherwise noted.

Lifetime Maximums: None.

Annual Maximums:

ABA/ABT services for autism spectrum disorder	\$40,000	\$40,000
---	----------	----------

Deductible

Individual, per calendar year	None	None
Family, per calendar year	None	None

Out-of-pocket Maximum

Individual, per calendar year	\$1,000	\$1,000
-------------------------------	---------	---------

Charges for the following do not apply to the Benefit Period **Out-of-pocket Maximum**

- Penalties for non-precertification or utilizing non-network providers
- **Out-of-pocket Maximums** are separate from the medical coverage **Out-of-pocket Maximums**.