



PacifiCare Behavioral Health of California, Inc. (PBHC)
& PacifiCare Life and Health Insurance Company (PLHIC)

Combined Evidence of Coverage and Disclosure Form
& Certificate of Coverage

Point of Service Parity Plan

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Introduction



WELCOME TO PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA

The PacifiCare Behavioral Health of California Point of Service Plan is very flexible and allows you and your eligible dependents to receive Behavioral Health Services from whomever you choose when you need them. Your benefits and coverage level may vary depending on your selection, but the choice is yours.

This handbook is separated into two parts. The first part is your In-Network Benefits as described in the *Combined Evidence of Coverage and Disclosure Form*. The second part is your Out-of-Network Benefits as described in the *Certificate of Coverage*. These documents will help you become more familiar with your Behavioral Health Services. These are legal documents that explain your Point of Service Behavioral Health Plan and should answer many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see Part I Section Ten “Definitions” of the *Combined Evidence of Coverage and Disclosure Form* and Part II Section Five “Definitions” of the *Certificate of Coverage*.

The *Combined Evidence of Coverage and Disclosure Form* and the *Certificate of Coverage* are key to making the most of your membership, and these documents should be read completely and carefully. All applicants have a right to view these documents prior to enrollment. Individuals with special behavioral health needs should carefully read sections that apply to them.

Part I: In-Network Benefits

Your most cost-effective option is to receive your Behavioral Health Services In-Network provided by PacifiCare Behavioral Health of California (PBHC) as described in Part I of this handbook. In-Network coverage offers you affordable, quality Behavioral Health Services at minimal out-of-pocket expense and there are very few, if any claim forms to complete. In-Network Behavioral Health Services are pre-authorized through PBHC, which determines the Behavioral Health Services that are Medically Necessary for you. All your services are provided through our PBHC Participating Providers. Once pre-authorized, PBHC arranges all Medically Necessary Behavioral Health Services and you are only required to pay a small Copayment. Note, however, that any services listed in Part I Section Four “Exclusions and Limitations of Benefits” are not covered.

Part II: Out-of-Network Benefits

If you prefer, you may have some of your Behavioral Health Services provided by a licensed Practitioner other than a PBHC Participating Provider and without prior authorization of PBHC. We call this option of obtaining your benefits “Out-of-Network” and PacifiCare Life and Health Insurance Company (“Company”) underwrites these benefits. The Out-of-Network portion of your Behavioral Health Plan covers Behavioral Health Services as described in Part II Section One “Out-of-Network Covered Services” of the *Certificate of Coverage*. Please note, however, that your out-of-pocket expenses will be significantly higher when you receive services Out-of-Network. If made apart of your Plan, you must satisfy your annual Deductible, pay the per visit Coinsurance amounts which are significantly higher, and pay any amount which the Practitioner charges which exceeds the Allowable Expense amount defined in Part II of the *Certificate of Coverage*. Also, you will need to file claim forms with the Company to receive payment. As with In-Network coverage, the services listed in Part II Section One “Exclusions and Limitations of Benefits” are not covered. Also you should know that certain services, such as inpatient care, are only covered as In-Network benefits.

What else should I read to understand my benefits?

Along with the *Combined Evidence of Coverage and Disclosure Form* and *Certificate of Coverage*, be sure to review your *Schedule of Benefits* and any supplemental benefit materials. Your *Schedule of Benefits* provides the details of your particular Behavioral Health Plan, including any Copayments that you may have to pay when accessing Behavioral Health Services. Together, these documents explain your coverage.

What if I still need help?

After you become familiar with your behavioral health benefits, you may still need assistance. Please do not hesitate to call our Customer Service Department at 1-800-999-9585 or for the hearing and speech impaired use 1-888-877-5378 (TDHI).

You may also correspond with PBHC at the following address:

**PacifiCare Behavioral Health
of California, Inc.
3120 Lake Center Drive
Santa Ana, California 92704-6917
Or visit the website: www.pbhi.com
Customer Service
1-800-999-9585
1-888-877-5378 (TDHI)
24 hours a day, seven days a week**



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PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA, INC. (PBHC)



Part I

In-Network Benefit Plan

Combined Evidence of Coverage and Disclosure Form

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Understanding Behavioral Health: Your In-Network Benefits

- *What are In-Network Behavioral Health Services?*
- *What is a Severe Mental Illness?*
- *What is the Serious Emotional Disturbance of a Child?*
- *What does PBHC do?*

This Section helps you understand what Behavioral Health Services are and provides a general understanding of some of the services PacifiCare Behavioral Health of California (PBHC) provides.

What are In-Network Behavioral Health Services?

Behavioral Health Services are those services provided or arranged by PBHC for the Medically Necessary treatment of:

- Mental Disorders, as defined in this *Combined Evidence of Coverage and Disclosure Form*, and/or
- Alcohol and drug problems, also known as Chemical Dependency, Substance Use or Substance Abuse.

What is a Severe Mental Illness?

A Severe Mental Illness (SMI) includes the diagnosis and treatment of the following conditions:

- Anorexia Nervosa
- Bipolar Disorder
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder

- Pervasive Developmental Disorder, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism.
- Schizoaffective Disorder
- Schizophrenia

What is the Serious Emotional Disturbance of a Child?

Serious Emotional Disturbance (SED) of a Child is defined as a condition of a child who:

- 1) Has one or more Mental Disorders as defined by the Diagnostic and Statistical Manual (DSM-IV-TR), other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms; and
- 2) Is under the age of eighteen (18) years old.
- 3) Furthermore, the child must meet one or more of the following criteria:
 - a. As a result of the Mental Disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
 - (i) the child is at risk of removal from home or has already been removed from the home, or
 - (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment,
 - b. The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a Mental Disorder; or
 - c. The child meets the special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7

Section One

Understanding Behavioral Health: Your In-Network Benefits



of Title 1 of the Government Code of the State of California.

What does PacifiCare Behavioral Health of California do?

PBHC arranges for the provision of Behavioral Health Services to our Members.

- You have direct 24-hour phone access to our services.
- Your Medically Necessary Behavioral Health Services are coordinated and paid for as provided under your Behavioral Health Plan, so long as you use PBHC Participating Providers.
- You may be responsible for payment of some Copayments or coinsurance amounts, as set forth in the attached *Schedule of Benefits*.

All services covered under this Behavioral Health Plan will be provided by a PBHC Participating Provider and must be pre-authorized by PBHC, except in the case of an Emergency. If you have questions about your benefits, simply call the PBHC Customer Service Department at 1-800-999-9585 at any time. Our staff is always there to assist you 24 hours a day, with understanding your benefits, authorizing services, helping you select a provider, or anything else related to your PBHC Behavioral Health Plan.

Your PBHC Behavioral Health Plan provides coverage for the Medically Necessary treatment of Mental Disorders and Chemical Dependency on both an inpatient and outpatient basis. Details concerning your behavioral health benefits can be found in your *Schedule of Benefits* and in Section 4 of this *Combined Evidence of Coverage and Disclosure Form*.



Section Two

Getting Started: Your Participating Provider

Getting Started: Your Participating Provider

- *Do I need a Referral?*
- *How do I Access Behavioral Health Services?*
- *Choice of Physicians and Providers*
- *What if I want to change my Participating Provider?*
- *Continuity of Care*

This Section explains how to obtain PacifiCare Behavioral Health of California (PBHC) Behavioral Health Services and the role of PBHC's Participating Providers.

Do I need a Referral from my Primary Care Physician to get Behavioral Health Services?

No. You can call PBHC directly to obtain Behavioral Health Services. If you would like us to, we will help coordinate the care you receive from your PBHC Participating Provider and the services provided by your Primary Care Physician ("PCP"). This may be very important when you have both medical and behavioral health conditions. PBHC will obtain the appropriate consents before information is released to your PCP. You may call PBHC Customer Service at any time to start this process.

How do I Access Behavioral Health Services?

Step 1

To access Behavioral Health Services, you must call PBHC first, except in an Emergency. Just call PBHC Customer Service at 1-800-999-9585. A PBHC staff member will make sure you are an eligible Member of the PBHC Behavioral Health Plan and answer any questions you may have about your benefits. The PBHC staff member will conduct a brief telephone

screening by asking you questions, such as:

- What are the problems or symptoms you are having?
- Are you already seeing a provider?
- What kind of provider do you prefer?

You will then be given the name and telephone number of one or more PBHC Participating Providers near your home or work that meets your needs.

Step 2

You call the PBHC Participating Provider's office to make an appointment.

Step 3

After your first Visit, your PBHC Participating Provider will get approval from PBHC for any additional services you need that are covered under the PBHC Behavioral Health Plan. You do not need to call PBHC again.

Choice of Physicians and Providers

PBHC's Participating Providers include hospitals, group practices, and licensed behavioral health professionals, which include psychiatrists, psychologists, social workers, and marriage and family therapists. All Participating Providers are carefully screened and must meet strict PBHC licensing and program standards.

Call the PBHC Customer Service Department for:

- Information on PBHC Participating Providers,
- Provider office hours,
- Background information on PBHC Participating Providers, such as their areas of specialization,
- A copy of our Provider Directory.

Facilities

Along with listing our Participating Providers, your PBHC Participating Provider directory has detailed information about our Participating Providers. This includes a quality index for helping you become familiar with our Participating Providers. If you need a copy

Section Two

Getting Started: Your Participating Provider



or would like assistance picking your Participating Provider, please call our Customer Service Department. You can also find an online version of the PBHC Participating Provider directory at www.pbhi.com.

What if I want to change my Participating Provider?

Simply call the PBHC Customer Service toll-free number at 1-800-999-9585 to select another PBHC Participating Provider.

If I see a Provider who is not part of PBHC's Provider Network, will it cost me more?

Yes. If you are enrolled in this PBHC Behavioral Health Plan and choose to see a provider who is not part of the PBHC network, the services will be excluded; and you will have to pay for the entire cost of the treatment (except in an Emergency) with no reimbursement from PBHC.

Can I call PBHC in the Evening or on Weekends?

Yes. If you need services after normal business hours, please call PBHC's Customer Service Department at 1-800-999-9585. For the hearing and speech impaired, use 1-888-877-5378 (TDHI). A staff member is always there to help.

Continuity of Care With a Terminated Provider

In the event your Participating Provider is no longer a part of the PBHC provider network for reasons other than breach of contract, a medical disciplinary cause, fraud or other criminal activity, you may be eligible to continue receiving care from that provider to ensure a smooth transition to a new Participating Provider and to complete a course of treatment with the same terminated Provider.

For a Member to continue receiving care from a terminated Provider, the following conditions must be met:

1. Continuity of Care services from a terminated Provider must be pre-authorized by PBHC;
2. The requested treatment must be a Covered Service under this Plan;
3. The terminated Provider must agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Provider prior to termination including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements, notwithstanding the provisions outlined in the provider contract related to Continuity of Care;
4. The terminated Provider must agree in writing to be compensated at rates and methods of payment similar to those used by PBHC for current Participating Providers providing similar services who are practicing in the same or a similar geographic area as the terminated Provider.

Covered Services for the Continuity of Care Condition under treatment by the Terminated or non-participating Mental Health Provider will be considered complete, when:

- i) the member's Continuity of Care Condition under treatment is medically stable, and
- ii) there are no clinical contraindications that would prevent a medically safe transfer to a Participating Mental Health Provider as determined by a PBHC Medical Director (or designee) in consultation with the Member, the Terminated Mental Health Provider and, as applicable, the Member's receiving Participating Provider.

All Continuity of Care requests will be reviewed on a case-by-case basis. Reasonable consideration will be given to the severity of the Member's condition and the potential clinical effect of a change in provider regarding the Member's treatment and outcome of the condition under treatment.

If you are receiving treatment for any of the specified Continuity of Care Conditions as limited and described in Section Ten, "Definitions," and believe



Section Two

Getting Started: Your Participating Provider

you qualify for continued care with the terminating Provider, please call the Customer Service Department and request the form “Request for Continuity of Care.” Complete and return the form to PBHC as soon as possible, but within thirty (30) calendar days of the provider effective date of termination.

If you have any questions about this provision or would like a copy of our Continuity of Care Policy, you may call our Customer Service Department.

Continuity of Care for New Members

Under certain circumstances, new Members of PBHC may be able to temporarily continue receiving services from a Non-Participating Provider. This short-term transition assistance may be available for a new Member who:

1. Did not have the option to continue with his/her previous behavioral health plan at time of enrollment;
2. Had no other behavioral health plan choice other than through PBHC;
3. Is under treatment by a Non-Participating Provider at the time of enrollment for an acute or serious chronic mental health condition;
4. Is receiving treatment that is a benefit under this PBHC Benefit Plan;
5. Was not offered a plan with an out-of-network option; and
6. Is new to PBHC as a result of the Members’ Employer Group changing health plans.

Behavioral Health Services provided by a Non-Participating Provider may be covered by PBHC for the purpose of safely transitioning you or your Dependent to a PBHC Participating Provider. If the Behavioral Health Services are pre-authorized by PBHC, PBHC may cover such services to the extent they would be covered if provided by a PBHC Participating Provider under the PBHC Behavioral Health Plan. This means that you will only be responsible for your Copayment or coinsurance listed on the

Schedule of Benefits and any services received will count towards your PBHC benefit plan limits. The Non-Participating Provider must agree in writing to the same contractual terms and conditions that are imposed upon PBHC Participating Providers, including reimbursement methodologies and rates of payment.

All services, except for Emergency Services, must be approved by PBHC

If you would like to request continuing treatment from a Non-Participating Provider, call the PBHC Customer Service Department as soon as reasonably possible within 30 days of your effective date with PBHC or prior to your effective date of coverage under the PBHC Behavioral Health Plan. If you have any questions or would like a copy of PBHC’s Continuity of Care policy, call or write the PBHC Customer Service Department.

Outpatient Treatment

For outpatient treatment, PBHC will authorize an appropriate number of Visits for you to continue treatment with the existing Non-Participating Provider in order to transition you safely to a PBHC Participating Provider.

Section Three

Emergency Services and Urgently Needed Services



Emergency Services and Urgently Needed Services

- *What is an Emergency?*
- *What are Psychiatric Emergency Services?*
- *What to do when you require Emergency Services?*
- *What to do when you require Urgently Needed Services*
- *Continuing or follow up of Emergency Treatment*
- *If I am out of State or traveling, am I still covered?*

Worldwide, wherever you are, PacificCare Behavioral Health of California (PBHC) provides coverage for Emergency Services and Urgently Needed Services. This section will explain how to obtain Emergency Services and Urgently Needed Services. It will also explain what you should do following receipt of these services.

IMPORTANT!

If you believe you are experiencing an Emergency condition, call 911 or go directly to the nearest hospital emergency room or other facility for treatment.

What is an Emergency?

An Emergency is defined as a condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate Behavioral Health Services could reasonably be expected by the Member to result in any of the following:

- Immediate harm to self or others;
- Placing your health in serious jeopardy;
- Serious impairment of your functioning; or
- Serious dysfunction of any bodily organ or part.

A situation will be considered an Emergency if you or your Dependent are experiencing a situation which requires the immediate provision of Behavioral Health Services such that a delay caused by seeking treatment from a PBHC Participating Provider would result in a serious deterioration to your mental health.

What are Psychiatric Emergency Services?

Psychiatric Emergency Services are Medically Necessary ambulance or ambulance transport services provided through the 911 Emergency response system. It includes the medical screening, examination and evaluation by a physician, or other licensed personnel – to the extent provided by law – to determine if a Psychiatric Emergency exists. If a Psychiatric Emergency condition exists, Psychiatric Emergency Services include the care and treatment by a physician necessary to stabilize or eliminate the Emergency condition within the capabilities of the facility.

What to do when you require Emergency Services?

Step 1

In an Emergency, get help or treatment immediately.

This means you should call “911” or go directly to the nearest medical facility for treatment.

Step 2

Then, within 48 hours of your Emergency, or as soon as is reasonably possible after your condition is stable, you, or someone acting on your behalf, must call PBHC at 1-800-999-9585.

This is important. Psychiatric Emergency Services are covered only as long as the condition continues to be an Emergency. Once the condition is under control and you can be safely transferred or discharged, additional charges incurred through the Emergency care facility will not be covered.



Section Three

Emergency Services and Urgently Needed Services

Step 3

PBHC will arrange follow up services for your condition after an Emergency. PBHC may move you to a Participating Provider in our network, as long as the move would not harm your health.

It is appropriate for you to use the “911” Emergency response system, or alternative Emergency system in your area, for assistance in an Emergency situation when ambulance transport services are required and you reasonably believe that your condition is immediate, serious and requires Emergency transport services to take you to the appropriate facility.

What to do when you require Urgently Needed Services

In-Area Urgently Needed Services

If you need Urgently Needed Services when you are in the geographic area served by your Participating Provider, you should contact your Participating Provider. If you are calling during non-business hours, and your Participating Provider is not immediately available, call PBHC Customer Service Department for assistance in finding a provider near your area. If your Participating Provider or PBHC is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a licensed behavioral health professional wherever you are located.

Out-of-Area Urgently Needed Services

Urgently Needed Services are required in situations where a Member is temporarily outside the geographic area served by the Member’s Participating Provider and the Member experiences a mental condition that, while less serious than an Emergency, could result in the serious deterioration of the Member’s mental health if not treated before the Member returns to the geographic area serviced by his or her Participating Provider.

When you are temporarily outside the geographic area served by your Participating Provider, and you believe that you require Urgently Needed Services, you should, if possible, call (or have someone else call on your

behalf) your Participating Provider. If you are calling during non-business hours, and your Provider is not immediately available, call PBHC Customer Service Department for assistance in finding a provider near your area. If your Participating Provider or PBHC is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a licensed behavioral health professional wherever you are located.

You, or someone else on your behalf, must notify PBHC or your Participating Provider within 24 hours, or as soon as reasonably possible, after the initial receipt of Urgently Needed Services.

It is very important that you follow the steps outlined above. If you do not, you may be financially responsible for services received.

Continuing or follow up of Emergency Treatment or Urgently Needed Services

If you require Behavioral Health Services following an Emergency or Urgently Needed Services and you desire that these services be covered, the Behavioral Health Services must be coordinated and authorized by PBHC. In addition, if a transfer does not create an unreasonable risk to your health, PBHC may require that you transfer to a PBHC Participating Provider designated by PBHC for any treatment following the Emergency or Urgently Needed Services.

Failure to transfer or to obtain approval from PBHC for continued treatment may result in all further treatment being denied if the services were not Medically Necessary or did not meet the Emergency or Urgently Needed Services criteria outlined in this document.

If I am out of State or traveling, am I still covered?

Yes, but only in an Emergency or Urgent situation. If you think you are experiencing an Emergency or require Urgently Needed Services, get treatment immediately. Then, as soon as reasonably possible, call PBHC Customer Service Department to ensure your

Section Three

Emergency Services and Urgently Needed Services



Emergency Treatment or Urgently Needed Services are covered. **This is important.**

If you are traveling outside of the United States, you can reach PBHC by calling 1-818-782-1100 for additional instructions on what to do in the case of an Emergency or Urgent situation.

Note: Under certain circumstances, you may need to pay for your Emergency or Urgently Needed Services at the time of treatment. If this is necessary, please pay for such services and then contact PBHC at the earliest opportunity. Be sure to keep all receipts and copies of relevant medical documentation. You will need these to be properly reimbursed. For more information on submitting claims to PBHC, please refer to Section 5 Payment Responsibility in this *Combined Evidence of Coverage and Disclosure Form*.



Covered In-Network Behavioral Health Services

- *What In-Network Behavioral Health Services are covered?*
- *Exclusions and Limitations of Benefits*

This section explains your Behavioral Health Benefits, including what is and is not covered by PacifiCare Behavioral Health of California (PBHC). You can find some helpful definitions in the back of this publication. For any Copayments that may be associated with a benefit, you need to refer to your *Schedule of Benefits*, a copy of which is included with this document.

What Behavioral Health Services are covered?

Behavioral Health Services are covered only when they are:

- **Incurred while the Member is eligible for coverage under this Behavioral Health Plan;**
- **Pre-authorized by PBHC as Medically Necessary; and**
- **Rendered by a PBHC Participating Provider, except in the case of an Emergency.**

PBHC will pay for the following Behavioral Health Services furnished in connection with the treatment of Mental Disorders and/or Chemical Dependency as outlined in the *Schedule of Benefits*, provided the above criteria have been satisfied. You should refer to your *Schedule of Benefits* for further information about your particular Behavioral Health Plan.

I. Mental Health Services:

A. Inpatient

1. *Inpatient Mental Health Services* provided at an Inpatient Treatment Center or Day Treatment Center are covered when Medically Necessary, pre-authorized by

PBHC, and provided at a Participating Facility.

2. *Inpatient Physician Care* – Medically Necessary Mental Health Services provided by a Participating Practitioner while the Member is hospitalized as an inpatient at an Inpatient Treatment Center or is receiving services at a Participating Day Treatment Center and which have been pre-authorized by PBHC.

B. Outpatient

1. *Outpatient Physician Care* – Medically Necessary Mental Health Services provided by a Participating Practitioner and pre-authorized by PBHC. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.

II. Chemical Dependency Services

A. Inpatient

1. *Inpatient Chemical Dependency Services, including Medical Detoxification provided at an Inpatient Treatment Center* – Medically Necessary Chemical Dependency Services, including Medical Detoxification, which have been pre-authorized by PBHC and are provided by a Participating Practitioner while the Member is confined in a Participating Inpatient Treatment Center, or at a Participating Residential Treatment Center.
2. *Inpatient Physician Care* – Medically Necessary Chemical Dependency Services, including Medical Detoxification, provided by a Participating Practitioner while the Member is confined at an Inpatient Treatment Center or at a Residential Treatment Center, or is receiving services at a Participating Day Treatment Center and which have been pre-authorized by PBHC.
3. *Chemical Dependency Services Rendered at a*

Section Four

Covered In-Network Behavioral Health Services



Residential Treatment Center – Medically Necessary Chemical Dependency Services provided by a Participating Practitioner, provided to a Member during a confinement at a Residential Treatment Center are covered, if provided or prescribed by a Participating Practitioner and pre-authorized by PBHC.

4. *Medical Detoxification* – Medical Detoxification services are covered when provided by a Participating Practitioner at a Participating Inpatient Treatment Center or at a Residential Treatment Center when pre-authorized by PBHC.

B. Outpatient

1. *Outpatient Physician Care* – Medically Necessary Chemical Dependency Services provided by a Participating Practitioner and pre-authorized by PBHC. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.

III. Other Behavioral Health Services

1. *Ambulance* – Use of an ambulance (land or air) for Emergencies including, but not limited to, ambulance or ambulance transport services provided through the “911” Emergency response system is covered without prior authorization when the Member reasonably believes that the behavioral health condition requires Emergency Services that require ambulance transport services. Use of an ambulance for a non-Emergency is covered only when specifically authorized by PBHC.
2. *Laboratory Services* – Diagnostic and therapeutic laboratory services are covered when ordered by a Participating Practitioner in connection with the Medically Necessary diagnosis and treatment of a Mental Disorder and/or Chemical Dependency when pre-authorized by PBHC.

3. *Inpatient Prescription Drugs* – Inpatient prescription drugs are covered only when prescribed by a PBHC Participating Practitioner for treatment of a Mental Disorder or Chemical Dependency while the Member is confined to an Inpatient Treatment Center or, in the case of treatment of Chemical Dependency, a Residential Treatment Center.
4. *Injectable Psychotropic Medications* – Injectable psychotropic medications are covered if prescribed by a PBHC Participating Practitioner for treatment of a Mental Disorder when pre-authorized by PBHC.
5. *Psychological Testing* – Medically Necessary psychological testing is covered when pre-authorized by PBHC and provided by a Participating Practitioner who has the appropriate training and experience to administer such tests.

Exclusions and Limitations of Benefits

Unless described as a Covered Service in an attached supplement, all services and benefits described below are excluded from coverage under this Behavioral Health Plan. Any supplement must be an attachment to this *Combined Evidence of Coverage and Disclosure Form*.

1. Any confinement, treatment, service or supply not authorized by PBHC, except in the event of an Emergency.
2. All services not specifically included in the PBHC *Schedule of Benefits* included with this *Combined Evidence of Coverage and Disclosure Form*.
3. Services received prior to the Member’s effective date of coverage, after the time coverage ends, or at any time the Member is ineligible for coverage.
4. Services or treatments which are not Medically Necessary, as determined by PBHC.
5. Services or treatment provided to you which duplicate the benefits to which you are entitled



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Covered In-Network Behavioral Health Services

under any applicable Workers' Compensation law are not covered, as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* titled 'Non-duplication of benefits with Workers' Compensation'.

6. Any services that are provided by a local, state or federal governmental agency are not covered except when coverage under this Behavioral Health Plan is expressly required by federal or state law.
7. Speech therapy, physical therapy and occupational therapy services provided in connection with the treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development.
8. Treatments which do not meet national standards for mental health professional practice.
9. Routine, custodial, and convalescent care, long term therapy and/or rehabilitation. (Individuals should be referred to appropriate community resources such as school district or regional center for such services).
10. Any services provided by non-licensed providers.
11. Pastoral or spiritual counseling
12. Dance, poetry, music or art therapy services except as part of a Behavioral Health Treatment Program
13. School counseling and support services, home based behavioral management, household management training, peer support services, recreation, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, wraparound services, Emergency aid to household items and expenses, and services to improve economic stability and interpretation services.
14. Genetic counseling services
15. Community Care Facilities that provide 24-hour non-medical residential care.
16. Weight control programs and treatment for addictions to tobacco, nicotine or food.
17. Counseling for adoption, custody, family planning or pregnancy in the absence of a DSM-IV-TR diagnosis.
18. Counseling, treatment or services associated with or in preparation for a sex (gender) reassignment operation are not covered.
19. Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence.
20. Personal or comfort items, and non-Medically Necessary private room and/or private duty nursing during inpatient hospitalization are not covered.
21. With the exception of injectable psychotropic medication as set forth in Section 4, all non-prescription and prescription drugs, which are prescribed during the course of outpatient treatment, are not covered. Outpatient prescription drugs may be covered under your medical plan. Please refer to the Member disclosure materials describing the medical benefit. (Non-prescription and prescription drugs prescribed by a PBHC Participating Practitioner while the Member is confined at an Inpatient Treatment Center and non-prescription and prescription drugs prescribed during the course of inpatient Emergency treatment whether provided by a Participating or Non-Participating Practitioner, are covered under the inpatient benefit.)
22. Surgery or acupuncture.
23. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not Medically Necessary.
24. Neurological services and tests, including, but not limited to, EEGs, Pet scans, beam scans, MRI's, skull x-rays and lumbar punctures.
25. Treatment sessions by telephone or computer Internet services.
26. Evaluation or treatment for education, professional

Section Four

Covered In-Network Behavioral Health Services



training, employment investigations, fitness for duty evaluations, or career counseling.

27. Educational services to treat developmental disorders, developmental delays or learning disabilities are not covered. A learning disability is a condition where there is a meaningful difference between a child's current academic level of function and the level that would be expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading and psychological and visual integration training as defined by the American Academy of Pediatrics Policy Statement - Learning Disabilities, Dyslexia and Vision: A Subject Review.
 28. Treatment of problems that are not Mental Disorders are not covered, except for diagnostic evaluation.
 29. Experimental and/or Investigational Therapies, Items and Treatments are not covered, unless required by an external, independent review panel as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Experimental and Investigational Therapies." Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by the PBHC Medical Director or a designee. For the purpose of this *Combined Evidence of Coverage and Disclosure Form*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines are met:
 - It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA), and such approval has not been granted at the time of its use or proposed use.
 - It is a subject of a current investigation of new drug or new device (IND) applications on file with the FDA.
 - It is the subject of an ongoing clinical trial (Phase I, II, or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and the Department of Health and Human Services.
- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
 - It is being delivered or should be delivered subject to approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
 - Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
 - The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
 - It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab test or imaging ordered to evaluate the effectiveness of the Experimental therapy).
 - The source of information to be relied upon by PBHC in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this Behavioral Health Plan, include but are not limited to the following:
 - The Member's Medical records;
 - The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;



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Covered In-Network Behavioral Health Services

- Any informed consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
 - The published authoritative medical and scientific literature regarding the drug, device, treatment or procedure;
 - Expert medical opinion;
 - Opinions of other agencies or review organizations (e.g., ECRI Health Technology Assessment Information Services or HAYES New Technology Summaries);
 - Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Healthcare Research and Quality (AHRQ);
 - PBHC Technology Assessment Committee Guidelines.
- A Member with a Life-Threatening or Seriously Debilitating condition may be entitled to an expedited external, independent review of PBHC's coverage determination regarding Experimental or Investigational therapies as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Experimental and Investigational Therapies".
30. Expenses incurred due to liable third parties are not covered, as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* titled "Reimbursement of Third Party Expenses".
31. Methadone maintenance treatment is not covered.

Section Five

In-Network Payment Responsibility



In-Network Payment Responsibility

- *Premiums and Copayments*
- *Reimbursement Provision*
- *How to Avoid Unnecessary Bills*
- *Coordination of Benefits with another Plan*
- *Third Party Expenses*
- *Medicare benefits*
- *Workers' Compensation*

One of the advantages of your Behavioral Health Care coverage is that most out-of-pocket expenses are limited to Copayments. This section explains these and other Behavioral Health Care expenses. It also explains your responsibility when you are eligible for Medicare or Workers' Compensation coverage and when PacifiCare Behavioral Health of California (PBHC) needs to coordinate your Benefits with another Plan.

Prepayment Fee

Premiums are fees that are received from your Employer Group to cover the basic cost of your Behavioral Health Services. These Premiums are usually paid on a monthly basis. Often the Subscriber shares the cost of these Premiums with deductions from his or her salary.

If you are the Subscriber, you should already know your contribution to your Premium payment. If you are not sure, contact your employer's health benefits representative. He or she will know if you are contributing to your Premium, as well as the amount, method, and frequency of this contribution.

Other Charges

Aside from the Premium, you may be responsible for paying a charge when you receive Behavioral Health Services. This charge is called a Copayment and is out-

lined in your *Schedule of Benefits*. As you review your *Schedule of Benefits*, you will see that the amount of the Copayment depends on the service, as well as the provider from whom you choose to receive your care.

Other Financial Responsibilities

The Member

Your Employer Group is responsible for submitting all of the Premiums for you to PBHC. However, your Employer Group may require that you pay a portion of the plan Premiums. Please contact your Employer Group for information on the method, amount and frequency of your contribution, if any.

In addition, please refer to the PBHC *Schedule of Benefits* for any applicable Benefit Maximums and/or Copayments that are applicable to your PBHC Behavioral Health Plan. PBHC will pay for Behavioral Health Services, pre-authorized by PBHC, as outlined in the *Schedule of Benefits* minus any applicable Copayments.

Unless you are experiencing an Emergency, you will be responsible for all charges if the services received are not pre-authorized by PBHC or if they are by a provider who is not a part of the PBHC Participating Provider network. Members are also responsible for all charges, even if they are pre-authorized by PBHC, if the Member is not an eligible Member for PBHC coverage at the time Behavioral Health Services are rendered.

In the event PBHC determines the services of a Non-Participating Provider do not meet the definition of an Emergency as defined in this *Combined Evidence of Coverage and Disclosure Form*, the Member may be liable to the Non-Participating Provider for the cost of services received.

CALIFORNIA LAW PROVIDES THAT ENROLLEES ARE NOT LIABLE FOR ANY AMOUNT OWED BY PBHC TO ANY PARTICIPATING PROVIDER IN THE EVENT PBHC DOES NOT PAY FOR PRE-AUTHORIZED SERVICES.



Section Five

In-Network Payment Responsibility

PacifiCare Behavioral Health of California

PBHC's Participating Providers will bill PBHC directly for the services they provide to you. PBHC reimburses Participating Providers for those Behavioral Health Services described in Section 4 of this *Combined Evidence of Coverage and Disclosure Form* which are pre-authorized by PBHC, furnished in connection with the Medically Necessary treatment of behavioral health conditions, and described in your *Schedule of Benefits*. No claim forms are necessary for any Behavioral Health Services, which are pre-authorized by PBHC.

Pre-authorized Services must also be:

1. Incurred while Member is eligible for PBHC benefits.
2. Pre-authorized for Medical Necessity as determined by PBHC guidelines, and
3. Rendered by a PBHC Participating Provider, except in the case of an Emergency.

Payments are subject to Copayments and Maximum Benefits while covered as described in the *Schedule of Benefits*.

Reimbursement Provision

If you are billed for Behavioral Health Services provided or authorized by your Participating Provider or if you receive a bill for Emergency or Urgently Needed Services, you should call the provider and let the provider know you have received a bill in error and you will be forwarding the bill to PBHC. Forward the bill to:

PacifiCare Behavioral Health of California, Inc.
Claims Department
P.O. Box 31053
Laguna Hills, CA 92654-1053

Note: Your Participating Provider will bill you for services that are not covered by PBHC or have not been properly authorized. You may also receive a bill if you have exceeded PBHC coverage limit for a benefit. These bills are your responsibility.

Bills from Non-Participating Providers

If you receive a bill for a Covered Service from a Provider who is not one of PBHC's Participating Providers, and the service was pre-authorized and you have not exceeded any applicable benefit limit, PBHC will pay for the services less the applicable Copayment. (Pre-authorization is not required for Emergency Services and Urgently Needed Services. See Section Three: Emergency and Urgently Needed Services in this *Combined Evidence of Coverage and Disclosure Form*.) You may also submit a bill to PBHC if a Non-Participating Provider has refused payment directly from PBHC.

You should file the bill within 90 days, or as soon as reasonably possible, following receipt of services. Forward the bill to:

PacifiCare Behavioral Health of California, Inc.
Claims Department
P.O. Box 31053
Laguna Hills, CA 92654-1053

Note: Be sure that the bill from the Non-Participating Provider includes the date(s) of service, the nature of the service (diagnosis and procedure(s) performed), the name and tax identification number of the provider who rendered the care. This will help PBHC pay the bill.

PBHC will make a determination within thirty (30) days from the date PBHC receives a claim containing all information reasonably necessary to process the claim. PBHC will not pay any claim that is filed more than one hundred and eighty (180) calendar days from the date the services were provided. PBHC also will not pay for excluded services unless authorized by your Participating Provider or directly by PBHC. If you have reached or exceeded any applicable benefit limit, these bills will be your responsibility.

How to Avoid Unnecessary Bills

Always obtain your care under the direction of PBHC or your Participating Provider. By doing this, you only will be responsible for paying for any related

Section Five

In-Network Payment Responsibility



Copayments and for charges in excess of your benefit limitations. Except for Emergency or Urgently Needed Services, if you receive services not authorized by PBHC or your Participating Provider, you may be responsible for payment. This is also true if you receive any services not covered by the PBHC Behavioral Health Plan.

Your Billing Protection

All PBHC Members have rights that protect them from being charged for Covered Services in the event a Participating Provider becomes insolvent, or a Participating Provider breaches its contract with PBHC. In none of these instances may the Participating Provider send you a bill, charge you, or have any other recourse against you for the Covered Services. However, this provision does not prohibit the collection of Copayment amounts as outlined in the *Schedule of Benefits*.

In the event of a Participating Provider's insolvency, PBHC will continue to arrange for your benefits. If for any reason PBHC is unable to pay for a Covered Service on your behalf (for instance, in the unlikely event of PBHC's insolvency or a natural disaster), you are not responsible for paying any bills as long as you received proper authorization from your PBHC Participating Provider or PBHC for such services.

Note: If you receive a bill because a Non-Participating Provider refused to accept payment from PBHC, you may submit a claim for reimbursement. See "Bills from Non-Participating Providers" in this *Combined Evidence of Coverage and Disclosure Form*.

Coordination of Benefits

If you or your Dependent(s) are covered by both PBHC and another plan or contract providing benefits or services for behavioral health, the services and benefits of your PBHC Behavioral Health Plan will be coordinated with the other plan. Coordination between these plans provides maximum coverage for

allowable expenses, thereby minimizing your out-of-pocket expenses and preventing costly duplication of payments.

The coordination of benefits provision is administered in accordance with the National Association of Insurance Commissioners (NAIC) guidelines and state regulations. In order to ensure proper coordination, you are required to notify PBHC of any other health or behavioral health coverage for which you or your Dependents may be eligible. If PBHC pays more benefits than appropriate, PBHC may recover excess benefit payments from you, the plan with the primary responsibility, or any other person or entity that benefited from the overpayment.

Reimbursement of Third Party Expenses

If you are ever injured by the actions or omissions of another person (a third party), receive coverage for that injury and then receive pre-authorized services under this PBHC Behavioral Health Plan, you will be required to reimburse PBHC or its nominee for the reasonable value of Behavioral Health Services provided. The amount of reimbursement will not exceed the amount paid out by PBHC on your behalf.

You must obtain PBHC's written consent prior to settling any claim or releasing any third party from liability if such a release would limit PBHC's right to reimbursement. Should you settle your claim against a third party and compromise PBHC's reimbursement rights, PBHC reserves the right to initiate legal action. Attorney fees will be awarded to the prevailing party. You are required to cooperate in protecting the interest of PBHC by providing PBHC with all liens, assignments or other documents.

Duplication of Benefits with Medicare

You must also notify PBHC if you are eligible for Medicare benefits. Under certain circumstances, PBHC may reduce its coverage to avoid duplication of benefits available from Medicare. If you are eligible for



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In-Network Payment Responsibility

Medicare, but fail to enroll in Medicare, your PBHC coverage will be reduced by the amount you could have received from Medicare. If you have questions regarding coordination with Medicare benefits, contact your Employer Group or the PBHC Customer Service Department. For answers to questions regarding Medicare eligibility, contact your local Social Security office.

Non-Duplication of Benefits with Workers' Compensation Insurance

PBHC will not cover services provided to you, which duplicate the benefits to which you are entitled under any applicable Workers' Compensation law. You are responsible for taking whatever action is necessary to obtain payment under Workers' Compensation laws where payment under that system can be reasonably expected. PBHC will not provide or arrange for benefits for a work-related illness when the Member fails to file a claim within the filing period allowed by law or fails to comply with other applicable provisions of law under the Workers' Compensation Act.

In the event PBHC, for any reason, provides benefits which duplicate the benefits to which you are entitled under Workers' Compensation law, you are required to reimburse PBHC, or its nominee, for the cost of all such services and benefits provided by PBHC, at prevailing rates, immediately upon obtaining a monetary recovery whether by settlement or judgment.

In the event of a dispute arising between you and your Workers' Compensation coverage regarding your ability to collect under Workers' Compensation laws, PBHC may provide those behavioral health benefits described in this *Combined Evidence of Coverage and Disclosure Form* until the dispute is resolved if the Member signs an agreement to reimburse PBHC for 100% of the benefits provided.

You and your Dependents are required to cooperate in protecting the interest of PBHC under this reimbursement provision by executing and delivering to PBHC or its nominee any and all liens, assignments or other documents.

Renewal Provisions

The *Group Subscriber Agreement* guarantees the benefits and rates for the period of that Agreement. Please contact your Employer Group to determine the term of the PBHC *Group Subscriber Agreement*. The PBHC *Group Subscriber Agreement* is automatically renewed for an additional period unless properly canceled by your Employer Group or PBHC. At the time of renewal, PBHC has the right to change Plan Premiums or other contract provisions. In addition, PBHC reserves the right to amend the Agreement in accordance with any state or federal mandated law or regulation.

In-Network Member Eligibility

Questions? Call our Customer Service Department at 1-800-999-9585.

Section Six

In-Network Member Eligibility



- *Membership Requirements*
- *Adding Family Members*
- *Termination of Benefits*
- *Updating Your Enrollment Information*
- *COBRA Benefits*
- *Total Disability*

This section describes how you become a PacifiCare Behavioral Health of California (PBHC) Member, as well as how you can add Family Members to your coverage. It will also answer other questions about eligibility, such as when late enrollment is permitted. In addition, you will learn ways you may be able to extend your PBHC coverage when it would otherwise terminate.

Membership Requirements

All Members must meet all eligibility requirements established by the Employer Group and PBHC. PBHC's Member eligibility requirements are:

- The Member must live or work within the PBHC Plan Service Area; and
- The Member must meet any other eligibility requirements established by the Employer Group, such as the age limit for providing coverage to unmarried children.

The effective date of coverage under this PBHC Behavioral Health Plan is the date of PBHC's verification of Member's eligibility provided by your Employer Group and contingent upon receipt of Plan Premiums. A Member who is eligible and enrolled in the PBHC Behavioral Health Plan will not be terminated from the Behavioral Health Plan due to his or her health status or need for Behavioral Health Services.

Your eligible Dependents are entitled to receive the same coverage under this Behavioral Health Plan as you do, provided they meet the requirements established by your Employer Group and PBHC. A written

request to enroll Dependents who become Dependents as a result of marriage, Domestic Partner, birth or adoption by a Subscriber must be made within thirty (30) days of the date of marriage, birth or date of adoption. (Guardianship is not a qualifying event for other Family Members to enroll.) Loss of eligibility of the Subscriber will terminate all of the Subscriber's Dependents in the PBHC Behavioral Health Plan.

Adding Family Members to your Coverage

Family Members are invited to enroll in the PBHC Behavioral Health Plan, as long as they meet your Employer Group's eligibility requirements. Please note that you may be asked to provide a marriage certificate, affidavit of domestic partnership, birth certificate or legal adoption paperwork. If you:

1. **Get married.** When a new Spouse or child becomes an eligible Family Member as a result of marriage, coverage begins on the first day of the month following the date of marriage. An application to enroll a Spouse or child eligible as a result of marriage must be made within 30 days of the marriage.
2. **Domestic Partnership.** When a new Domestic Partner or Domestic Partner's child becomes an eligible Family Member as a result of a domestic partnership, coverage begins on the first day of the month following the date of the domestic partnership. An application to enroll a Domestic Partner or child eligible as a result of a domestic partnership must be made within 30 days of the domestic partnership.
3. **Have a baby.** Newborns are covered for the first 30 days of life. In order for coverage to continue beyond the first 30 days of life, the Subscriber must submit a Change Request Form to PBHC prior to the expiration of the 30-day period.
4. **Adoption or Placement for Adoption.** Receive an adoptive placement from a recognized county or private agency, or adopted as documented by



Section Six In-Network Member Eligibility

health facility minor release form, a medical authorization from or a relinquishment form, granting you or your Spouse or Domestic Partner the right to control the health care for the adoptive child or absent such a document, on the date there exists evidence of the Subscriber's, Spouse's or Domestic Partner's right to control the health care of the child placed for adoption. For adopted children, coverage is effective on the date of adoption or placement for adoption. An application must be received within 30 days of the adoption placement.

5. **Guardianship.** To enroll a Dependent child for whom the Subscriber has assumed legal guardianship, the Subscriber must submit a Change Request Form to PBHC along with a certified copy of a court order granting guardianship within 30 days of when the Subscriber assumed legal guardianship. Coverage will be retroactively effective to the date the Subscriber assumed legal guardianship.

Contact your Employer Group for additional information on all aspects of your eligibility under the PBHC Behavioral Health Plan.

Qualified Medical Child Support Order

A Member (or a person otherwise eligible to enroll in the PBHC Behavioral Health Plan) may enroll a child who is eligible to enroll in the PBHC Behavioral Health Plan upon presentation of a request by a District Attorney, State Department of Health Services or a court order to provide medical support for such a Dependent child without regard to any enrollment period restrictions.

A person having legal custody of a child or a custodial parent who is not a PBHC Member may ask about obtaining Dependent coverage as required by a court administrative order, including a Qualified Medical Child Support Order, by calling PBHC's Customer Service Department. A copy of the court or administrative order must be included with the enrollment application. Information including, but not limited to, *Combined Evidence of Coverage and Disclosure Form* or other available information, including notice of termi-

nation, will be provided to the custodial parent, caretaker and/or District Attorney. Coverage will begin on the first of the month following receipt by PBHC of an enrollment form with the court or administrative order attached.

Except for Emergency and Urgently Needed Services, to receive coverage, all care must be provided or arranged in the PBHC Service Area by the designated Participating Provider, as selected by the custodial parent or person having legal custody.

Continuing Coverage for Students and Disabled Dependents

Certain Dependents who would otherwise lose coverage under the Behavioral Health Plan due to their attainment of the Limiting Age established by the Employer Group may extend their coverage under the following circumstances:

- **Continuing Coverage for Student Dependents.** An unmarried Dependent who is a registered as a full-time student at a certified educational institution and is carrying a course load of a minimum of twelve (12) credit hours, or an equivalent, each academic period may continue as an eligible Dependent through the Limiting Age established by the employer for full-time students, if proof of such status is provided to PBHC on a periodic basis, as requested by PBHC. If the Dependent student resides outside of the Service Area, the student must maintain a permanent address inside the Service Area with the Subscriber and the student must select a Participating Provider within 30 miles of that address. All Behavioral Health Services must be provided or arranged for in the Service Area by the designated Participating Provider, except for Emergency and Urgently Needed Services.
- **Continuing Coverage for Certain Disabled Dependents.** Unmarried enrolled Dependents, who attain the Limiting Age established by the employer, may continue enrollment in the Behavioral Health Plan beyond the Limiting Age if the unmarried Dependent meets all the following:

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In-Network Member Eligibility



1. The unmarried Dependent resides within the Service Area with the Subscriber or the Subscriber's separated or divorced Spouse or the terminated Domestic Partner.
2. The unmarried Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap;
3. The unmarried Dependent is chiefly dependent upon the Subscriber for support and maintenance; and
4. The mental or physical condition existed continuously prior to reaching the Limiting Age.

In order to continue coverage under this section for qualifying disabled Dependents, proof of such disability and dependency must be provided to PBHC by the Member within 31 days of the onset of the disability, attainment of the Limiting Age or at the time of the Subscriber's initial enrollment in PBHC.

PBHC may require ongoing proof of a Dependent's disability and dependency, but not more frequently than annually after the two-year period following the Dependent's attainment of the Limiting Age. This proof may include supporting documentation from a state or federal agency or a written statement by a licensed psychologist, psychiatrist or other Physician to the effect that such disabled Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap.

Late Enrollment

In addition to a special enrollment period due to the addition of a new Spouse, Domestic Partner or child, there are certain circumstances when Eligible Employees and their eligible Family Members may enroll outside of the employer's enrollment period. These circumstances include:

- The eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) decline in writing to enroll in PBHC when they were first eligible because they had other health coverage; and

- PBHC cannot produce a written declination statement from the Employer Group or eligible employee stating that the eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) was provided with and a signed acknowledgment of explicit written notice in boldface type specifying that failure to elect coverage with PBHC during the initial enrollment period permits the plan to impose an exclusion of coverage under the Behavioral Health Plan for a period of 12 months from the date of election of coverage under the Behavioral Health Plan, unless the eligible employee or Family Member can demonstrate that he or she meets the requirements for late enrollment.
- The other Behavioral Health Services are no longer available due to:
 1. The employee or eligible Family Member exhausting COBRA continuation coverage under another plan;
 2. The termination of employment or reduction in work hours of a person through whom the employee or eligible Family Member was covered; or
 3. The termination of the other plan coverage; or
 4. The cessation of an employer's contribution toward the employee or eligible Family Member coverage; or
 5. The death, divorce or legal separation of a person through whom the employee or eligible Family Member was covered.
- The Court has ordered behavioral health coverage to be provided for your Spouse or minor child.

Termination of Benefits

Usually, your enrollment in PBHC terminates when the Subscriber or enrolled Family Member is no longer eligible for coverage under the employer's Behavioral Health Plan. In most instances, your Employer Group determines the date in which coverage will terminate. Coverage can be terminated, however, because of other



Section Six In-Network Member Eligibility

circumstances as well, which are described below.

Cancellation of the Group Contract for Nonpayment of Premiums

Continuing coverage under this Behavioral Health Plan is subject to the terms and conditions of the *Group Subscriber Agreement* between your Employer Group and PBHC. If the *Group Subscriber Agreement* is cancelled because the Employer Group failed to pay the required Premiums when due, then coverage for you and all your Dependents will end 15 days after PBHC mails you the Notice Confirming Termination of Coverage.

PBHC will mail your Employer Group a notice at least 15 days before any cancellation of coverage. This Prospective Notice of Cancellation will provide information to your Employer Group regarding the consequences of your Employer Group's failure to pay the Premiums due within 15 days of the date the notice was mailed.

If payment is not received from your Employer Group within 15 days of the date the Prospective Notice of Cancellation is mailed, PBHC will cancel the *Group Subscriber Agreement* and mail the Subscriber of the Plan a Notice Confirming Termination of Coverage, which will provide the Subscriber with the following information:

- That the *Group Subscriber Agreement* has been cancelled for non-payment of Premiums;
- The specific date and time when your Employer Group coverage ends, which will be no sooner than 15 days after the Notice of Confirming Termination of Coverage is mailed.

Reinstatement of the Contract after Cancellation

If the *Group Subscriber Agreement* is cancelled for the Employer Group's nonpayment of Premiums, then PBHC will permit reinstatement of the *Group Subscriber Agreement* once during any twelve-month period if the Employer Group pays the amounts owed within 15 days of the date of the Notice Confirming Termination of Coverage.

Member Termination for Non-Eligibility

In addition to terminating the *Group Subscriber Agreement*, PBHC may terminate a Member's coverage for any of the following reasons:

- The Member no longer meets the eligibility requirements established by the Group Employer and/or PBHC;
- The Member lives or works outside the State of California;
- The Member lives or works outside the PBHC Service Area and does not work inside the PBHC Service Area (except for a child subject to a qualified child medical support order. For more information refer to "Qualified Medical Child Support Order" in this section).

Ending Coverage – Special Circumstances for Enrolled Family Members

Enrolled Family Members terminate on the same date of termination as the Subscriber. If there is a divorce, the Spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered. Dependent children lose their eligibility if they marry or reach the Limiting Age established by the employer and do not qualify for extended coverage as a student Dependent or as a disabled Dependent.

Termination for Good Cause

PBHC has the right to terminate your coverage under this Behavioral Health Plan in the following situations:

- **Failure to Pay.** Your coverage may be terminated if you fail to pay any required Copayments, coinsurance or charges owed to a Provider or PBHC for Covered Services. To be subject to termination under this provision, you must have been billed by the Provider for two different billing cycles and have failed to pay or make appropriate payment arrangements with the Provider. PBHC will send you written notice, and you will be subject to termination if you do not pay or make appropriate payment arrangements within the thirty (30) day notice period.
- **Fraud or Misrepresentation.** Your coverage may

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be terminated, benefits denied or rates modified if you knowingly provide false information (or misrepresent a meaningful fact) on your enrollment form, (this includes adding dependents that do not meet the eligibility requirements of the Employer Group and PBHC as defined in this document and proof of eligibility may be requested at any time PBHC deems necessary); or fraudulently or deceptively use services or facilities of PBHC, its Participating Medical Group or other health care Providers (or knowingly allow another person to do the same), including altering a prescription. Termination is effective immediately on the date PBHC mails the notice of termination, unless PBHC has specified a later date in that notice.

- **Disruptive Behavior.** Your coverage may be terminated if you threaten the safety of Plan employees, Providers, Members or other patients, or your repeated behavior has substantially impaired PBHC's ability to furnish or arrange services for you or other Members, or substantially impaired Provider(s) ability to provide services to other patients. Termination is effective 15 days after the notice is mailed to the Subscriber.

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the COBRA Plan and lose the right to re-enroll in PBHC in the future.

Under no circumstances will a Member be terminated due to health status or the need for Behavioral Health Services. Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for Behavioral Health Services may request a review of the termination by the California Department of Managed Health Care. For more information contact our Customer Service Department.

NOTE: If a *Group Subscriber Agreement* is terminated by PBHC, reinstatement with PBHC is subject to all terms and conditions of the *Group Subscriber Agreement* between PBHC and the Employer Group.

Notifying you of changes in your Behavioral Health Plan

Amendments, modifications or termination of the *Group Subscriber Agreement* by either the Employer Group or PBHC do not require the consent of a Member. PBHC may amend or modify the Behavioral Health Plan, including the applicable Premiums, at any time after sending written notice to the Employer Group at least sixty (60) days prior to the effective date of any amendment or modification. Your Employer Group may also change your Behavioral Health Plan benefits during the contract year. In accordance with PBHC's *Group Subscriber Agreement*, the Employer Group is obliged to notify employees who are PBHC Members of any such amendment or modification.

Updating your Enrollment Information

Please notify your employer of any changes to the information you provided on the enrollment application within sixty (60) days of the change. This includes changes to your name, address, telephone number, marital status or the status of any enrolled Family Member. For reporting changes in marital status and/or Dependent status, please see "Adding Family Members" in this *Combined Evidence of Coverage and Disclosure Form*. If you wish to change your Participating Provider, you may contact PBHC Customer Services Department at 1-800-999-9585, or for the hearing and speech impaired, 1-888-877-5378 (TDHI).

Federal COBRA Continuation Coverage

If your Employer Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), you and your covered Dependents may be entitled to continuation coverage under your Employer Group's health care plan. Members may qualify for continuation of coverage if they lose coverage for one of the following reasons:

1. Termination or separation from employment for reasons other than gross misconduct.
2. Reduction of work hours.



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3. Subscriber's death.
4. Your Spouse ceases to be eligible for coverage due to divorce or legal separation.
5. A Dependent child ceases to be an eligible Dependent.

Under COBRA, you are responsible for notifying your Group (or, if applicable, its COBRA administrator) of a divorce, legal separation or a child losing Dependent status under your Group's Health Plan within sixty (60) days of the date of the event. Your Group has the responsibility to notify its COBRA administrator of a Subscriber's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, Spouses and Dependent children if your Employer Group commences a bankruptcy proceeding and these individuals lose coverage.

When the COBRA administrator is notified that one of these events has happened, the COBRA administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least sixty (60) days from the date you would lose coverage because of one of the events described above to inform the COBRA administrator that you want continuation coverage.

If you do not choose continuation coverage on a timely basis, your group health plan coverage under this Group Health Plan will end and you will be financially responsible for payment of any Behavioral Health Services that you have received after your terminating event.

If you choose continuation coverage, your Employer Group is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Behavioral Health Plan to similarly situated employees or Family Members. COBRA permits you to maintain continuation coverage for up to 36 months, unless you have lost your group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This initial 18-month period may be extended for affected individuals

up to 36 months from termination of employment if other events (such as death, divorce, legal separation or Medicare entitlement) occur during that initial 18-month period. In addition, the initial 18-month period may be extended up to 29 months if you are determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage. Please contact your Employer Group (or its COBRA administrator) for more information regarding the applicable length of COBRA continuation coverage available.

Please note that under COBRA, the continuation coverage may be cut short for any of the following reasons:

1. Your Employer Group no longer provides group health coverage to any of its employees;
2. The Premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered after the date he or she elects COBRA continuation coverage under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA continuation coverage; or
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

You are responsible for the timely submission of the COBRA Premium to the Employer Group (or COBRA administrator). Your Employer Group (or COBRA administrator) is responsible for the timely submission of Premium to PBHC.

If you have any questions about COBRA, please contact your Employer Group.

California Continuation Coverage After COBRA

In the event your COBRA coverage began on or after

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January 1, 2003 and you have exhausted your COBRA benefits, you may be eligible to continue benefits under “Cal-COBRA” as described below, at 110% of the Premium charged for similarly situated eligible employees currently working at your former employment. A notice will be provided to you at the time your COBRA benefits will exhaust, allowing up to 18 months, but not to exceed 36 months from the date COBRA benefits began.

State Continuation Coverage Under “Cal-COBRA”

The California Continuation Benefits Replacement Act (“Cal-COBRA”), requires that Employer Groups with fewer than 20 eligible employees on at least 50% of its working days during the preceding Calendar Year, or, if the Employer Group was not in business during any part of the preceding Calendar Year, employed 2 to 19 eligible employees on at least 50% of its working days during the preceding calendar quarter, offer eligible employees and their families the opportunity for a temporary extension of coverage (called “continuation of coverage”) in certain instances where coverage under the Behavioral Health Plan would otherwise end.

Qualifying Events

A Subscriber who is an employee of an Employer Group with fewer than 20 employees and is enrolled in its behavioral health benefit plan has a right to choose Cal-COBRA continuation coverage if any of the following Qualifying Events occur, resulting in a loss of coverage under the group benefit plan:

1. The termination of Subscriber’s employment (for reasons other than gross misconduct); or
2. The reduction in hours of Subscriber’s employment.

Covered Spouses or Dependents of an employee have the right to choose continuation coverage if any of the following Qualifying Events occur:

1. The death of the Subscriber;
2. The termination of the Subscriber’s employment (for reasons other than gross misconduct) or reduction in the hours of employment;

3. Divorce or legal separation from the Subscriber;
4. The Dependent child ceases to be a Dependent under the terms of this Behavioral Health Plan; or
5. The Subscriber becomes entitled to Medicare.

Notification Requirement

It is the responsibility of the Subscriber’s Employer Group to notify PBHC if either of the following two Qualifying Events occur resulting in a loss of group coverage: (i) Subscriber’s termination of employment or (ii) Subscriber’s reduction in hours of employment. With respect to all other Qualifying Events (i.e., death, divorce or legal separation, loss of Dependent status, and entitlement to Medicare), it is the responsibility of the Subscriber or qualified beneficiary to notify PBHC of the occurrence of any such Qualifying Event. This notification must be made in writing within sixty (60) days of the date of the Qualifying Event and delivered to PBHC by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier. Failure to provide the required notification within sixty (60) days of the Qualifying Event will disqualify the qualified beneficiary from receiving continuation coverage.

The notification should also include the following information and be mailed to the address below:

1. The name of the Member;
2. The date of the Qualifying Event and the type of Qualifying Event as listed above;
3. The name of the Employer Group and the group plan number; and
4. The name and address of all qualified beneficiaries.

PacificCare Behavioral Health of California, Inc.
3100 Lake Center Drive
Santa Ana, CA 92704-6917
Attn. Group Administration

Election and Enrollment

When PBHC is notified that one of these events has occurred, we will in turn notify the Member that he or she has the right to choose continuation coverage. If a Member wishes to choose continuation coverage, he or



Section Six In-Network Member Eligibility

she must deliver a completed enrollment application within sixty (60) days of the later of:

1. The date of receipt of notice from PBHC that the Member has the right to Cal-COBRA continuation coverage; or
2. The date the Member's coverage under the Employer Group Plan terminated or will terminate.

If the Member elects continuation coverage, the coverage will be effective on the day after coverage would otherwise be terminated. Cal-COBRA continuation coverage will be the same as the coverage provided by the Employer to similarly situated employees and Dependents. Members do not have to show that they are insurable to choose continuation coverage; however, they will pay 110% of the applicable Premium charged to similarly situated individuals under the *Group Subscriber Agreement*. If they do not elect coverage and do not pay the appropriate Premium, their benefit coverage will terminate in accordance with the provisions outlined in this *Evidence of Coverage and Disclosure Form*.

Premium Payments

The Cal-COBRA Premium will generally be 110% of the Premium charged to the Employer Group for similarly active employees. In the case of a qualified beneficiary who is determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, the qualified beneficiary shall be required to pay an amount no greater than 150 percent of the group rate after the first 18 months of Cal-COBRA continuation coverage. The first Premium payment must be submitted to PBHC by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, within 45 days of delivering the completed enrollment form. The payment must cover the period from the last day of the prior coverage to the present. There can be no gap between prior coverage and Cal-COBRA continuation coverage. Failure to submit the correct Premium within the 45-day period noted above will disqualify the Member from receiving continuation coverage. All subsequent

payments are due on the first day of each coverage month. If prepayment fees are not received within thirty (30) days of the due date, continuation coverage will be canceled on midnight of the last day for which payment was last made.

Termination of Cal-COBRA Coverage

Cal-COBRA continuation coverage will be terminated at the first to occur of the following:

1. In the case of a qualified beneficiary who is eligible for Cal-COBRA coverage due to the termination of employment or a reduction in hours of employment, 36 months from the date Cal-COBRA continuation coverage commenced;
2. The end of the period for which Premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required Premium;
3. In the case of a qualified beneficiary who is eligible for continuation coverage due to death, divorce or legal separation, loss of Dependent status, or entitlement to Medicare, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a Qualifying Event;
4. The qualified beneficiary is no longer entitled to Cal-COBRA coverage because he or she (a) becomes eligible for Medicare; (b) becomes covered under another group benefit that does not impose any exclusion or limitation with respect to any preexisting condition; (c) becomes eligible for federal COBRA coverage; (d) becomes eligible for coverage under the Public Health Service Act; or (e) fails to submit the correct Cal-COBRA Premium amount, or fails to satisfy other terms and conditions of the plan contract;
5. The employer, or any successor employer or purchaser of the employer, ceases to provide any behavioral health group benefit coverage to his or her employees; or
6. The qualified beneficiary moves out of the Behavioral Health Plan's Service Area or commits fraud

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or deception in the use of Behavioral Health Plan services.

A Member who is eligible for continuation coverage due to a loss of employment or reduction in hours worked, and determined, under Title II or XVI of the Social Security Act, to be disabled at any time during the first sixty (60) days of continuation of coverage, and the Spouse or Dependent who has elected coverage, is eligible for 36 months of Cal-COBRA coverage, beginning from the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event. The qualified Member shall notify PBHC of the social security determination within sixty (60) days of the date of the determination letter and prior to the end of the original 36-month continuation coverage period. PBHC will charge 150% of the applicable Premium after the initial 18 months of continuation coverage. The qualified Member must notify PBHC within thirty (30) days upon the determination that the qualified Member is no longer disabled under Title II or XVI of the Social Security Act.

Early Termination of Group Contract

If the *Group Subscriber Agreement* between your Employer Group and PBHC is terminated prior to the date your continuation coverage would terminate under Cal-COBRA, you may elect continuation coverage under the new group benefit plan, if any, for the remainder of the time period you would have been covered by PBHC. If there is a new group benefit plan, you must contact the new benefit plan for details on continuing coverage through the plan. Please note that continuation coverage will terminate if you fail to comply with the requirements pertaining to enrollment in, and payment of Premiums to the new benefit plan within thirty (30) days of receiving notice by PBHC of the termination of its group contract with your employer.

Individuals Ineligible for Cal-COBRA

The following individuals are not eligible for Cal-COBRA continuation coverage:

1. Individuals who are entitled to Medicare;
2. Individuals who are covered under another group benefit that does not impose any exclusion or limitation with respect to any preexisting condition;
3. Individuals who are eligible for federal COBRA coverage;
4. Individuals who are eligible for coverage under the Public Health Service Act, such as government employees and their Dependents;
5. Individuals who fail to meet the requirements set forth above relating to notification of a Qualifying Event or election of continuation coverage; and
6. Individuals who fail to submit the correct Cal-COBRA Premium amount, or fail to satisfy other terms and conditions of the plan contract.

Total Disability

If you or your enrolled Dependent(s) is Totally Disabled as a result of a behavioral health condition at the time your Employer Group's Agreement with PBHC is terminated and you or your enrolled Dependent(s) continue to be Totally Disabled, PBHC will continue to provide coverage to the Totally Disabled Member for the behavioral health condition causing the Total Disability for up to twelve (12) months or until the Member is covered under another Health Plan which does not have an enforceable pre-existing condition clause.

To qualify for these benefits, you must provide written proof of the behavioral health disability acceptable to PBHC within ninety (90) days of the date on which coverage for your entire Employer Group was terminated. Also see the definition of "Totally Disabled or Total Disability" in the definitions section of this *Combined Evidence of Coverage and Disclosure Form*. PBHC may require you to periodically submit additional information to verify your behavioral health Total Disability.



Overseeing Your In-Network Behavioral Health Services

- *How PBHC Makes Important Benefit Decisions*
- *Second Opinions*
- *New Treatments and Technologies*
- *Experimental and Investigational Therapies*
- *Appealing a Behavioral Health Benefit Decision*
- *Independent Medical Review*

This section explains how PacifiCare Behavioral Health of California (PBHC) authorizes or makes changes to your Behavioral Health Services, how we evaluate new behavioral health technologies and how we reach decisions about your coverage.

You will also find out what to do if you are having a problem with your Behavioral Health Plan, including how to appeal a behavioral health benefit decision by PBHC or one of our Participating Providers. You will learn the process that is available for filing a formal grievance, as well as how to request an expedited decision when your condition requires a quicker review.

How PBHC Makes Important Benefit Decisions

Authorization, Modification and Denial of Behavioral Health Services

When a Member requests Mental Health Services or Chemical Dependency Services, PBHC uses established utilization management (UM) criteria to approve, deny, delay or modify authorization of benefits based on Medical Necessity. The criteria used for evaluating Mental Health Services are based on empirical research and industry standards. These are the *MCAP Behavioral Health Criteria*. For Chemical Dependency Services, PBHC uses the *American Society of Addiction Medicine Placement Guidelines for Substance Related Disorder - Version II-Revised*. The UM criteria used to deny, delay, or modify requested

services in the Member's specific case will be provided free of charge to the Participating Provider and to the Member. The public is also able to receive specific criteria or guidelines, based on a particular diagnosis, upon request.

If you or your Dependent(s) are receiving Behavioral Health Services from a school district or a regional center, PBHC will coordinate with the school district or regional center to provide Case Management of your Behavioral Health Treatment Program. Upon PBHC's request, you or your Dependent(s) may be required to provide a copy of the most recent Individual Education Plan (IEP) that you or your Dependent(s) received from the school district and/or the most recent Individual Program Plan (IPP) or Individual Family Service Plan (IFSP) from the regional center to coordinate these services.

The PBHC qualified physician or other appropriate qualified licensed health care professional, and its Participating Providers make decisions to deny, delay, or modify requests for authorization of Behavioral Health Services, based on Medical Necessity, within the following timeframes as required by California state law:

- Decisions based on Medical Necessity will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days from PBHC's receipt of information reasonably necessary to make the decision.
- If the Member's condition poses an imminent and serious threat to his/her health, including, but not limited to, severe pain, potential loss of life, limb, or other major bodily functions, or lack of timeliness would be detrimental in regaining maximum functions, the decision would be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed seventy-two (72) hours after PBHC's receipt of the information reasonably necessary and requested by PBHC to make the determination.

If the decision cannot be made within these timeframes because (i) PBHC is not in receipt of all

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the information reasonably necessary and requested, or (ii) PBHC requires consultation by an expert reviewer, or (iii) PBHC has asked that an additional examination or test be performed upon the Member, provided the examination or test is reasonable and consistent with good medical practice, PBHC will notify the Participating Provider and the Member, in writing, that a decision cannot be made within the required timeframe. The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by PBHC, then PBHC shall approve or deny the request for authorization within the timeframe specified above as applicable.

PBHC notifies requesting Participating Providers of decisions to deny or modify request for authorization of Behavioral Health Services of Members within twenty-four (24) hours of the decision. Members are notified of decisions, in writing, within two (2) business days of the decision. The written decision will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, and information about how to file an appeal of the decision with PBHC. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Member.

If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an “Urgent Request” as defined above, PBHC will modify or deny the request as soon as possible, taking into account the Member’s behavioral health condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to PBHC at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an Urgent Request as defined above, PBHC will treat the request as a new request for a Covered Service under the Behavioral Health Plan and

will follow the timeframe for non-Urgent requests as discussed above.

If you would like a copy of PBHC’s description of processes utilized for the authorization or denial of Behavioral Health Services, or the criteria or guidelines related to a particular condition, you may contact the PBHC Customer Service Department or visit the PBHC Website at www.pbhi.com.

Second Opinions

A Member, or his or her treating PBHC Participating Provider, may submit a request for a second opinion to PBHC either in writing or verbally through the PBHC Customer Service Department. Second opinions will be authorized for situations, including but not limited to, when:

- the Member questions the reasonableness or necessity of recommended procedures;
- the Member questions a diagnosis or plan for care for a condition that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment, including but not limited to a chronic condition;
- the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition and the Member requests an additional diagnosis;
- the Treatment Plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; or
- the Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

The request for a second opinion will be approved or denied by PBHC’s Medical Director (or designee) in a



timely fashion appropriate for the nature of your or your Dependent's condition. For circumstances other than an imminent or serious threat to your health, a second opinion request will be approved or denied within five (5) business days after the Participating Provider or PBHC receives the request. When there is an imminent and serious threat to your behavioral health, a decision about your second opinion will be made within 72 hours after receipt of the request by your Participating Provider or PBHC.

If you are requesting a second opinion about care given by your Participating Provider, the second opinion will be provided by an appropriately qualified behavioral health professional of your choice within the same Participating Provider Network. If you request a second opinion about care received from a specialist, the second opinion will be provided by any behavioral health care professional of your choice from within the same Participating Provider Network. The Participating Provider providing the second opinion will possess the clinical background, including training and expertise, related to the illness or condition associated with the request for a second opinion.

If there is no qualified Participating Provider within the network, then PBHC will authorize a second opinion by an appropriately qualified behavioral health professional outside the Participating Provider network. In approving a second opinion either inside or outside of the Participating Provider network, PBHC will take into account the ability of the Member to travel to the provider.

A second opinion will be documented by a consultation report which will be made available to you. If the Provider giving the second opinion recommends a particular treatment, diagnostic test or service covered by PBHC, and it is determined to be Medically Necessary by your Participating Provider, the treatment, diagnostic test or service will be provided or arranged by the Member's Participating Provider. However, the fact that a provider furnishing a second opinion recommends a particular treatment, diagnostic test or service does not necessarily mean that the treatment, diagnostic test or service is Medically

Necessary or a Covered Service under your PBHC Behavioral Health Plan. You will be responsible for paying any Copayment, as set forth in your *Schedule of Benefits*, to the PBHC Provider who renders the second opinion. If you obtain a second opinion without pre-authorization from your Participating Provider or PBHC, you will be financially responsible for the cost of the opinion.

If you or your Dependent's request for a second opinion is denied, PBHC will notify you in writing and provide the reason for the denial. You or your Dependent may appeal the denial by following the procedures outlined in the appeals section described later in this *Combined Evidence of Coverage and Disclosure Form*.

To receive a copy of the Second Opinion policy, you may call or write the PBHC Customer Service Department at:

PacifiCare Behavioral Health of California, Inc.
Post Office Box 55307
Sherman Oaks, California 91413-0307
1-800-999-9585

How are New Treatments and Technologies Evaluated?

PBHC is committed to evaluating new treatments and technologies in behavioral health care. A committee composed of PBHC's Medical Director and people with subject matter expertise meet at least once a year to assess new advances and programs.

Experimental and Investigational Therapies

PBHC also provides an external, independent review process to review its coverage decisions regarding Experimental or Investigational Therapies for PBHC Members who meet all of the following criteria:

1. You have a Life-Threatening or Seriously Debilitating condition, as defined below and it meets the criteria listed in items #2, #3, #4 and #5 below:

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- “Life-threatening” means either or both of the following: (i) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (ii) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
 - “Seriously Debilitating” means diseases or conditions that cause major, irreversible morbidity.
2. Your PBHC Participating Provider certifies that you have a Life-Threatening or Seriously Debilitating condition, as defined above, for which standard therapies have not been effective in improving your condition, or for which standard therapies would not be medically appropriate for you, or for which there is no more beneficial standard therapy covered by PBHC than the therapy proposed pursuant to paragraph (3); and
 3. Either (a) your PBHC Participating Provider has recommended a treatment, drug, device, procedure, or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, and he or she included a statement of the evidence relied upon by the Participating Provider in certifying his or her recommendation; or (b) you, or your non-contracting physician who is a licensed, board-certified or board-eligible physician or provider qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from medical and scientific evidence (as defined in California Health and Safety Code Section 1370.4(d)), is likely to be more beneficial for you than any available standard therapy.

Such certification must include a statement of the evidence relied upon by the physician in certifying his or her recommendation. PBHC is not responsible for the payment of services rendered by non-contracting providers that are not otherwise

covered under the Member’s PBHC benefits; and

4. A PBHC Medical Director (or designee) has denied your request for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph (3); and
5. The treatment, drug, device, procedure, or other therapy recommended pursuant to paragraph 3, above, would be a covered service, except for PBHC’s determination that the treatment, drug, device, procedure, or other therapy is Experimental or Investigational. Independent Medical Review for coverage decisions regarding Experimental or Investigational therapies will be processed in accordance with the protocols outlined under “Independent Medical Review Involving a Disputed Health Care Service” Section of this *Evidence of Coverage*.

Please refer to the “Independent Medical Review of Grievances Involving a Disputed Health Care Service” Section found later in this *Combined Evidence of Coverage and Disclosure Form* for more information.

What to do if you have a problem?

Our first priority is to meet your needs and that means providing responsive service. If you ever have a question or problem, your first step is to call the PBHC Customer Service Department for resolution.

If you feel the situation has not been addressed to your satisfaction, you may submit a formal complaint within 180 days of your receipt of an initial determination over the telephone by calling the PBHC toll-free number at 1-800-999-9585. You can also file a complaint in writing:

PacifiCare Behavioral Health of California, Inc.
Post Office Box 55307
Sherman Oaks, CA 91413-0307
Attn: Appeals Department

Or at the PBHC website: www.pbhi.com



Appealing a Behavioral Health Benefit Decision

The individual initiating the appeal may submit written comments, documents, records, and any other information relating to the appeal regardless of whether this information was submitted or considered in the initial determination. The Member may obtain, upon request and free of charge, copies of all documents, records, and other information relevant to the Member's appeal. An individual, who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person, will review the appeal.

The PBHC Medical Director (or designee) will review your appeal and make a determination within a reasonable period of time appropriate to the circumstances but not later than thirty (30) days after PBHC's receipt of the appeal, except in the case of "expedited reviews" discussed below. For appeals involving the delay, denial, or modifications of Behavioral Health Services, PBHC's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying, or modifying Behavioral Health Services based on a finding that the services are not Covered Services, the response will specify the provisions in the plan contract that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of this *Combined Evidence of Coverage and Disclosure Form* captioned PBHC Quality Review Process.

Binding Arbitration and Voluntary Mediation

If the Member is dissatisfied with the appeal, the Member may submit or request that PBHC submit the appeal to voluntary mediation and/or binding arbitration before Judicial Arbitration and Mediation Service ("JAMS"). Such voluntary mediation or binding arbitration will be limited to claims that are

not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Voluntary Mediation – In order to initiate mediation, the Member or agent acting on behalf of the Member shall submit a written request for voluntary mediation. If the parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with JAMS Mediation Rules and Procedures, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.

Binding Arbitration – Any and all disputes of any kind whatsoever, including, claims for medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligent, or incompetently rendered), except for claims subject to ERISA, between Member (including any heirs, successor or assigns of Member) and PBHC, or any of its parents, subsidiaries or affiliates shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. Member and PBHC are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single arbitrator in accordance with the Comprehensive Arbitration Rules and Procedures of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor mutually to agree to the appointment of the arbitrator; but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Arbitration Rules and Procedures will be utilized.

Arbitration hearings shall be held in the county in which the Member lives or at such other location as the parties may agree in writing. Civil discovery

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may be taken in such arbitration. The arbitrator selected shall have the power to control the timing, scope, and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California; including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by Federal and California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, PBHC may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. Please contact PBHC for more information on how to obtain a hardship application. The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein. The Federal Arbitration Act, 9 U.S.C. SS 1-16, shall also apply to the arbitration.

BY ENROLLING IN PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA (PBHC) BOTH MEMBER (INCLUDING ANY HEIRS, SUCCESSOR OR ASSIGNS OF MEMBER) AND PBHC AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO A JURY TRIAL AND INSTEAD VOLUNTARILY AGREE TO THE USE OF BINDING ARBITRATION AS DESCRIBED IN THIS *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM*.

Expedited Review Process

Appeals involving an imminent or serious threat to the

health of the Member, including, but not limited to, severe pain, potential loss of life, limb, or other major bodily functions will be immediately referred to the PBHC Medical Director for expedited review, regardless of whether such appeal is received orally or in writing. If an appeal has been sent to the PBHC Medical Director for immediate expedited review, PBHC will immediately inform the Member, in writing, of his or her right to notify the Department of Managed Health Care with a written statement of the disposition or pending status of the expedited review no later than three (3) days from receipt of complaint. The Department of Managed Health Care may waive the requirement that you complete the appeals process or participate in the appeals process for at least thirty (30) days if the Department of Managed Health Care determines that an earlier review is necessary.

Independent Medical Review of Grievances involving a disputed Behavioral Health Service

A Member may request an Independent Medical Review ("IMR") of disputed Behavioral Health Services from the Department of Managed Health Care ("DMHC") if the Member believes that Behavioral Health Services have been improperly denied, modified, or delayed by PBHC. A "disputed Behavioral Health Service" is any Behavioral Health Service eligible for coverage under the *Evidence of Coverage* that has been denied, modified, or delayed by PBHC, in whole or in part because the service requested by you or your Provider was based on a finding that the requested service is Experimental or Investigational or is not Medically Necessary. The Member must meet the criteria described in the Eligibility section to see if his or her grievance qualifies for an IMR. The IMR process is in addition to the procedures and remedies that are available to the Member under the PBHC Appeal Process described above. If your complaint or appeal pertains to a disputed Behavioral Health Service subject to IMR (as discussed below), you should file your complaint or appeal within 180 days of receiving a denial notice.



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Overseeing Your In-Network Behavioral Health Services

Completed applications for IMR should be submitted to the DMHC. The Member pays no fee to apply for IMR. The Member has the right to include any additional information or evidence not previously provided to PBHC in support of the request for IMR. PBHC will provide the Member with an IMR application form with any grievance disposition letter that denies, modifies, or delays Behavioral Health Services. The Member may also reach the DMHC by calling 1-888-HMO-2219. The DMHC fax number is 1-916-229-0465.

A decision not to participate in the IMR process may cause the Member to forfeit any statutory right to pursue legal action against PBHC regarding the disputed Behavioral Health Service.

IMR Eligibility for Independent Medical Review Experimental or Investigational Treatment Decisions

If you suffer from a Life-Threatening or Seriously Debilitating condition, you may have the opportunity to seek IMR of PBHC's coverage decision regarding Experimental or Investigational therapies under California's Independent Medical Review System pursuant to Health and Safety Code Section 1370.4. Life-Threatening means either or both of the following: (a) conditions where the likelihood of death is high unless the course of the condition is interrupted; (b) conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. Seriously Debilitating means conditions that cause major, irreversible morbidity.

To be eligible for IMR of Experimental or Investigational treatment, your case must meet all of the following criteria:

1. Your Provider certifies that you have a Life-Threatening or Seriously Debilitating condition for which:
 - Standard therapies have not been effective in improving your condition, or
 - Standard therapies would not be medically appropriate for you, or

- There is no more beneficial standard therapy covered by PBHC than the proposed Experimental or Investigational therapy proposed by your Provider under the following paragraph.
2. Either (a) your PBHC Provider has recommended a treatment, drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, and he or she has included a statement of the evidence relied upon by the Provider in certifying his or her recommendation; or (b) you or your non-contracting Provider – who is a licensed, board certified or board-eligible Provider qualified to practice in the specialty appropriate to treating your condition – has requested a therapy that, based on two documents of medical and scientific evidence identified in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial than any available standard therapy. To satisfy this requirement, the Provider certification must include a statement detailing the evidence relied upon by the Provider in certifying his or her recommendation. (Please note that PBHC is not responsible for the payment of services rendered by non-contracting Providers who are not otherwise covered under your PBHC benefits.)
 3. A PBHC Medical Director has denied your request for a treatment or therapy recommended or requested pursuant to the above paragraph
 4. The treatment or therapy recommended pursuant to Paragraph 2 above would be a Covered Service, except for PBHC's determination that the treatment, drug, device, procedure or other therapy is Experimental or Investigational.

If you have a Life-Threatening or Seriously Debilitating condition and PBHC denies your request for Experimental or Investigational therapy, PBHC will send a written notice of the denial within five (5) business days of the decision. The notice will advise you of your right to request IMR, and include a Provider certification form and an application form with a pre-

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Overseeing Your In-Network Behavioral Health Services



addressed envelope to be used to request IMR from the DMHC. (Please note that you may request an IMR, if PBHC denied your request for Experimental or Investigational Therapy, without going through the PBHC grievance process.)

Disputed Behavioral Health Services Regarding Medically Necessity

You may also request IMR when any Behavioral Health Service has been denied, modified or delayed by PBHC or one of its Providers, in whole or in part, due to a finding that the service is not Medically Necessary. (Note: Disputed Behavioral Health Services do not encompass coverage decisions. Coverage decisions are decisions that approve or deny services substantially based on whether or not a particular service is included or excluded as a covered benefit under the terms and conditions of your coverage.)

You are eligible to submit an application to the DMHC for IMR of a Disputed Behavioral Health Service if you meet all of the following criteria:

- The Member's provider has recommended a Behavioral Health Service as Medically Necessary; or
- The Member has received Urgently Needed Services or Emergency Services that a provider determined was Medically Necessary; or
- The Member has been seen by a PBHC Participating Provider for diagnosis or treatment of the medical condition for which the Member sought independent review;
- The disputed Behavioral Health Service has been denied, modified, or delayed by PBHC, based in whole or in part on a decision that the Behavioral Health Service is not Medically Necessary; and
- The Member has filed a grievance with PBHC and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If the grievance requires expedited review, the Member may bring it immediately to the DMHC's attention. The DMHC may waive the preceding requirement that the Member follow PBHC's

grievance process in extraordinary and compelling cases.

Accepted Applications for the Independent Medical Review

Upon receiving a Member's application for IMR, the DMHC will review the request and notify the Member whether the Member's case has been accepted. If the Member's case is eligible for IMR, the dispute will be submitted to an independent medical review organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of PBHC, who will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of behavioral health professionals knowledgeable in the treatment of the Member's conditions, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither the Member nor PBHC will control the choice of expert reviews.

PBHC must provide the following documents to the IRO within three business days of receiving notice from the DMHC that the Member has successfully applied for an IMR:

- The relevant medical records in the possession of PBHC or its Participating Providers;
- All information provided to the Member by PBHC and any of its Participating Providers concerning PBHC and Participating Provider decision regarding the Member's condition and care (including a copy of PBHC's denial notice sent to the Member).
- Any materials that the Member or Provider submitted to PBHC and its Participating Providers in support of the request for the Behavioral Health Services.
- Any other relevant documents or information used by PBHC or its Participating Providers in determining whether the Behavioral Health Services should have been provided and any statement by PBHC or its Participating Providers explaining the reason for the decision. PBHC will provide copies



of these documents to the Member and the Member's Provider unless any information in them is found by the DMHC to be privileged.

If there is an imminent and serious threat to the Member's health, PBHC will deliver the necessary information and documents listed above to the IRO within 24 hours of approval of the request for IMR.

After submitting all of the required materials to the IRO, PBHC will promptly issue the Member a notification that includes an annotated list of the documents submitted and offer the Member the opportunity to request copies of those documents from PBHC.

If there is any information or evidence the Member or the Member's Provider wish to submit to the DMHC in support of IMR that was not previously provided to PBHC, the Member may include this information with the IMR application to the DMHC. Also as required, the Member or the Member's Provider must provide to the DMHC or the IRO copies of any relevant behavioral health records, and any newly developed or discovered relevant records after the initial documents are provided, and respond to any requests for additional records or other relevant information from the expert reviewers.

The Independent Medical Review Decision

The independent review panel will render its analysis and recommendations on the Member's IMR case in writing, and in layperson terms to the maximum extent practical, within thirty (30) days of receiving the Member's request for IMR and supporting information. The time may be adjusted under any of the following circumstances:

- In the case of a review of Experimental or Investigational determination, if the Member's Provider determines that the proposed treatment or therapy would be significantly less effective if not promptly initiated. In this instance, the analysis and recommendations will be rendered within seven days of the request for expedited review. The review period can be extended up to three days for a delay in providing required documents at the request of the expert.

- If the Behavioral Health Services have not been provided and the Member's Provider or the DMHC certifies in writing that an imminent and serious threat to the Member's life exist, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of the Member's health. In this instance, any analyses and recommendation of the experts must be expedited and rendered within three days of the receipt of the Member's application and supporting information.
- If approved by the DMHC, the deadlines for the expert reviewers' analyses and recommendations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

The IRO will provide the DMHC, PBHC, the Member and the Member's Provider with each of the experts' analyses and recommendations, and a description of the qualifications of each expert. The IRO will keep the names of the expert reviewers confidential, except in cases where the reviewer is called to testify and in response to court orders. In the case of an Experimental or Investigational determination, the experts' analyses will state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial to the Member than any available standard therapy and the reasons for recommending why the therapy should or should not be provided by PBHC, citing the Member's specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the expert's recommendation. In the case of a review of a disputed health care service denied as not Medically Necessary, the experts' analyses will state whether the disputed health care service is Medically Necessary and cite your medical condition, the relevant documents in the record and the reviewer's relevant findings.

The recommendation of the majority of the experts on the panel will prevail. If the experts on the panel are evenly divided as to whether the Behavioral Health Services should be provided, the panel's decision will

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Overseeing Your In-Network Behavioral Health Services



be deemed to be in favor of coverage. If the majority of the experts on the panel does not recommend providing the Behavioral Health Services, PBHC will not be required to provide the service.

When a Decision is Made

The DMHC will immediately adopt the decision of the IRO upon receipt and will promptly issue a written decision to the parties that will be binding on PBHC. PBHC will promptly implement the decision when received from the DMHC. In the case of an IRO determination requiring reimbursement for services already rendered, PBHC will reimburse either the Member or the Member's Provider, whichever applies, within five (5) working days. In the case of services not yet rendered to the Member, PBHC will authorize the services within five (5) working days of receiving the written decision from the DMHC, or sooner if appropriate for the nature of the Member's medical condition and will inform the Member and the Member's Provider of the authorization.

PBHC will promptly reimburse the Member for reasonable costs associated with Urgently Needed Services or Emergency Services outside of the PBHC Participating Provider network, if:

- The services are found by the IRO to have been Medically Necessary;
- The DMHC finds the Member's decision to secure services outside of PBHC's Participating Provider network prior to completing the PBHC grievance process or seeking IMR was reasonable under the circumstances; and
- The DMHC finds that the disputed health care services were a covered benefit under the PBHC *Group Subscriber Agreement*.

Behavioral Health Services required by IMR will be provided subject to the terms and conditions generally applicable to all other benefits under the PBHC Plan.

For more information regarding the IMR process, or to request an application, the Member should contact the PBHC Customer Service Department at 1-800-999-9585.

The PBHC Quality Review Process

The quality review process is a Member-initiated internal review process that addresses Member concerns regarding the quality or appropriateness of services provided by PBHC Participating Providers that has the potential for an adverse effect on the Member. Upon receipt of the Member's concern, the concern is referred to the Quality Improvement Department for investigation.

PBHC takes great pride in the quality of our Participating Providers. That is why complaints specifically about the quality of the care you receive from your Participating Provider are handled in an expedited fashion. Quality of care complaints that affect a Member's current treatment will be immediately evaluated and if necessary, other appropriate PBHC personnel and the PBHC Participating Provider will be consulted.

The Quality Improvement Manager (or designee) will be responsible for responding to questions the Member may have about his or her complaint and about the Quality Review process. In appropriate instances, a meeting may be arranged between the Member and the Participating Provider.

The relevant medical records will be obtained from the appropriate providers and reviewed by the PBHC Quality Improvement Manager (or designee). If necessary, a letter is sent to the Participating Provider, as appropriate, requesting further information. Additional information will be received and reviewed by the Quality Improvement Manager (or designee). After reviewing the medical records, the case may be referred to the Peer Review Committee for review and recommendation of corrective action against the PBHC Participating Provider involved, if appropriate.

If the Member has submitted a written complaint, the Member will be notified of the completion in writing within thirty (30) days. The oral and written communications involving the Quality Review Process and the results of the review are confidential and cannot be shared with the Member. The outcome of the Quality Review Process cannot be submitted to voluntary



mediation or binding arbitration as described above under the PBHC Appeals Process. The Quality Improvement Manager will follow up to ensure that any corrective actions against a Participating Provider are carried out.

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care services plans.

If you have a grievance against your health plan, you should first telephone your health plan at 1-800-999-9585 or 1-888-877-5378 (TDHI) and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal right or remedies that may be available to you. If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatment that are Experimental or Investigational in nature and payment disputes for Emergency or Urgently Needed medical services.

The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

Section Eight

Member Rights and Responsibilities



Member Rights and Responsibilities

- *Your rights as a partner in your Behavioral Health Services*
- *PBHC Member Responsibilities*
- *Confidentiality of Information*
- *Tell us what you think*

Think of PacifiCare Behavioral Health of California (PBHC) as part of your behavioral health care team. We want to work with you to ensure you receive the treatment and support you need. This Section describes the rights and responsibilities you have as a Member of PBHC.

Your rights as a partner in your Behavioral Health Services

PBHC believes in your rights as a partner in your own behavioral health care. PBHC wants to give you all the information you need - in every day language, not just medical words. Your rights include:

- Members have the right to receive information regarding how PBHC protects the welfare and safety of Members and Care Managers.
- Members have the right to receive timely, quality care.
- Members have the right to receive information about PBHC services, contracted providers, clinical guidelines and Case Management processes.
- Members have the right to be treated with respect and recognition of their dignity and need for privacy.
- Members have a right to participate with Participating Provider(s) in decision-making regarding their treatment planning.
- Members have a right to a candid discussion of appropriate and Medically Necessary treatment

alternatives, regardless of cost or benefit coverage.

- Members have the right to voice complaints about the organization or the care provided as well as the right to appeal treatment authorizations, claims payment, or benefit interpretation decisions made by PBHC without discrimination.
- Members may make recommendations regarding PBHC's Member Rights and Responsibilities policies.

PBHC will protect your rights regardless of your gender, age, sexual orientation, marital status, culture, or economic, educational or religious background. These rights can also be given to the person you have named to make decisions about your health care. For more information on Member rights, visit the PBHC website (www.pbhi.com).

PBHC Member Responsibilities

As a Member, you have many important responsibilities. These responsibilities include the following:

- Members have the responsibility to review information regarding Covered Services, exclusions, limitations, or Copayments and policies and procedures as stated in Member materials and this *Combined Evidence of Coverage and Disclosure Form*.
- Members have a responsibility to provide, to the extent possible, information that either PBHC or its Participating Provider(s) need(s) in order to provide for their care.
- Members have a responsibility to follow the Treatment Plans and instructions for care that they have agreed upon with their provider(s).
- Members have a responsibility to participate, to the degree possible, in understanding their behavioral health conditions and developing mutually agreed upon treatment goals.
- Members have the responsibility to conduct themselves in a manner that supports the care provided to other patients within an inpatient



Section Eight Member Rights and Responsibilities

facility as well as to not disrupting the general functioning of the facility.

- Members have the responsibility to accept financial responsibility for any Copayment or coinsurance associated with services received while under the care of a PBHC Participating Provider or while a patient at a PBHC Participating Facility.

you are denied services you feel are part of your benefits, you can file an appeal. To find out how to do this, please refer to the appeals process in Section Seven of this *Combined Evidence of Coverage and Disclosure Form*.

Confidentiality of Information

PBHC takes the subject of Member confidentiality very seriously and takes great measures to protect the confidentiality of all Member information in its possession, including the protection of treatment records and personal information. PBHC provides information only to the professionals delivering your treatment or as otherwise required by law. Confidentiality is built into the operations of PBHC through a system of control and security that protects both written and computer-based information.

A statement describing PBHC's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request. If you would like a copy of PBHC's confidentiality policies and procedures, you may call our Customer Service Department at 1-800-999-9585.

Tell us what you think

Your questions and suggestions are important to us.

- Call or write PBHC's Customer Service Department with all questions and concerns about your care.
- Give us your recommendations on how to improve your health plan, our customer service or our rights and responsibilities policies.
- Call or write the PBHC Customer Service Department if you have a complaint.
- Ask any questions about the medical advice or treatment that you are getting.

Additionally, you have the right to voice complaints or file appeals about the organization or care provided. If

Questions? Call our Customer Service Department at 1-800-999-9585.

Section Nine

General Information



General Information

- *Translation Assistance*
- *Speech and Hearing Impaired Assistance*
- *Coverage in Extraordinary Circumstances*
- *Compensation for Providers*
- *Organ and Tissue Donation*
- *What to do if you suspect health care fraud?*
- *Public Policy Participation*

What follows are answers to some questions about your PacificCare Behavioral Health of California (PBHC) coverage. If you have any questions of your own that have not been answered, please call our Customer Service Department.

Does PBHC offer a Translation Service?

PBHC uses a telephone translation service for almost 140 languages and dialects. That is in addition to the selection of Customer Service representatives who are fluent in a language other than English.

Does PBHC offer Hearing and Speech Impaired Telephone Lines?

PBHC has a dedicated telephone number for the hearing and speech impaired. The telephone number is 1-888-877-5378 (TDHI).

How is my coverage provided under Extraordinary Circumstances?

In the unfortunate event of a major disaster, epidemic, war, riot, civil insurrection, or complete or partial destruction of facilities, our Participating Providers will do their best to provide the services you need. Under these extreme conditions, go to the nearest doctor or hospital for Emergency Services. PBHC will later provide appropriate reimbursement.

How Does PBHC Compensate Its Participating Providers?

PBHC itself is not a provider of Behavioral Health Services. PBHC typically contracts with independent providers to provide Behavioral Health Services to its Members and with hospitals to provide hospital services. Once they are contracted, they become PBHC Participating Providers. PBHC's network of Participating Providers includes individual Practitioners, group practices, and facilities.

PBHC Participating Providers, who are groups, or facilities, may in turn employ or contract with individual Psychiatrists, Psychologists or other licensed behavioral health professionals. None of the Participating Providers or their employees are employees or agents of PBHC. Likewise, neither PBHC nor any employee of PBHC is an employee or agent of any Participating Provider.

Our PBHC Participating Providers are paid on a discounted fee-for-service basis for the services they provide. They have agreed to provide services to you at the normal fee they charge, minus a discount. PBHC does not compensate nor does it provide any financial bonuses or any other incentives to its Providers based on their utilization patterns.

If you would like to know more about fee-for-service reimbursement, you may request additional information from the PBHC Customer Service Department or your PBHC Participating Provider.

How do I become an Organ and Tissue Donor?

Transplantation is one of the most remarkable success stories in the history of medicine. It's the only hope for thousands of people suffering from organ failure or in desperate need of corneas, skin, bone or other tissue. Tragically, the need for donated organs and tissues continues to outpace the supply. Nearly 50,000 Americans are waiting for organ transplants while hundreds of thousands more need tissue transplants. Organ and tissue donation provides each of us with a



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special opportunity to help others. You can save lives and enable recipients to return to work and lead productive lives and others to see for the first time.

Almost everyone can be a donor. There is no age limit and the number of donors age 50 or older has increased. If you have concerns about organ donation, speak with your family, doctor, clergy member or friends. Most importantly, get the information you need to make a responsible decision that you and your family support.

Sharing your decision to be an organ and tissue donor with your family is as important as making the decision itself. Your organs and tissue will not be donated unless a Family Member gives consent at the time of your death – even if you have signed your driver's license or a donor card. A simple family conversation will prevent confusion or uncertainty about your wishes.

It is also helpful to document your decision by completing a donor card in the presence of your family and having them sign as witnesses. The donor card serves as a reminder to your family and medical staff of your personal decision to be a donor. Carry it in your wallet or purse at all times.

How can I learn more about being an Organ and Tissue Donor?

To get your donor card and information on organ and tissue donation:

- Call 1-800-355-SHARE or 1-800-633-6562.
- Request Donor Information from your local Department of Motor Vehicles (DMV).
- On the Internet, contact:
 - All About Transplantation and Donation at www.transweb.org
 - Dept. of Health & Human Services at www.organdonor.gov
- Sign the donor card in your family's presence.
- Have your family sign as witnesses and pledge to

carry out your wishes and keep the card with you at all times where it can be easily found.

- Remember, even if you've signed something, you must tell your family so they can act on your wishes.

What do you do if you suspect health care fraud?

PBHC takes health care fraud by its Participating Providers or by its employees very seriously and has taken great measures to prevent, detect and investigate health care fraud. PBHC has put in place policies and procedures to address fraud and report fraud to the appropriate law enforcement and regulatory entities in the investigation and prosecution of health care fraud. If you suspect fraud by any PBHC Participating Provider or any PBHC employee, please call the PBHC anti-fraud hotline at 1-888-777-3465.

How can I participate in PBHC'S Public Policy Participation?

PBHC affords its Members the opportunity to participate in establishing its public policy. For the purpose of this paragraph, "public policy" means acts performed by PBHC and its employees to assure the comfort, dignity and convenience of Members who rely on Participating Providers to provide Covered Services. One third of PBHC's Board of Directors is comprised of PBHC Members. If you are interested in participating in the establishment of PBHC's public policy, please call the PBHC Customer Service Department for more details.

Section Ten

In-Network Definitions



In-Network Definitions

PacificCare Behavioral Health of California is dedicated to making its services easily accessible and understandable. To help you understand the precise meaning of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your *Combined Evidence of Coverage and Disclosure Form*, as well as the *Schedule of Benefits*. Please refer to the *Schedules of Benefits* to determine which of the definitions below apply to your benefit plan.

Behavioral Health Services. Services for the Medically Necessary diagnosis and treatment of Mental Disorders and Chemical Dependency, which are provided to Members pursuant to the terms and conditions of the PBHC Behavioral Health Plan.

Behavioral Health Plan. The PBHC Behavioral Health Plan that includes coverage for the Medically Necessary diagnosis and treatment of Mental Disorders and Chemical Dependency, as described in the Behavioral Health *Group Subscriber Agreement*, this *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits*.

Behavioral Health Treatment Plan. A written clinical presentation of the PBHC Participating Provider's diagnostic impressions and therapeutic intervention plans. The Behavioral Health Treatment Plan is submitted routinely to PBHC for review as part of the concurrent review monitoring process.

Behavioral Health Treatment Program. A structured treatment program aimed at the treatment and alleviation of Chemical Dependency and/or Mental Disorders.

Benefit Plan Design. The specific behavioral health Benefit Plan Design for a Behavioral Health Plan which describes the benefit coverage, pertinent terms and conditions for rendering Behavioral Health Services, and the exclusions or limitations applicable to the Covered Behavioral Health Services.

Calendar Year. The period of time commencing 12:00

A.M. on January 1 through 11:59 P.M. on December 31.

Case Management. A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's behavioral health needs based on Medical Necessity, behavioral health benefits and available resources in order to promote a quality outcome for the individual Member.

Chemical Dependency. An addictive relationship between a Member and any drug, alcohol or chemical substance that can be documented according to the criteria in the DSM-IV-TR. Chemical Dependency does not include addiction to or dependency on (1) tobacco in any form or (2) food substances in any form.

Chemical Dependency Inpatient Treatment Program. A structured medical and behavioral inpatient program aimed at the treatment and alleviation of Chemical Dependency.

Chemical Dependency Services. Medically Necessary services provided for the diagnosis and treatment of Chemical Dependency, which have been pre-authorized by PBHC.

Continuity of Care Condition(s). The completion of Covered Services will be provided by a terminated Participating Provider to a Member who, at the time of the Participating Provider's contract termination, was receiving any of the following Covered Services from that Participating Provider:

1. An Acute Condition: An acute condition is a behavioral health condition that involves a sudden onset of symptoms due to an illness, or other behavioral health problems that require prompt medical attention and that have a limited duration. Completion of Covered Services will be provided for the duration of the acute condition.
2. A Serious Chronic Condition: A serious chronic condition is a behavioral health condition due to illness or other behavioral health conditions that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time



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reasonably necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a provider, as determined by the PBHC Medical Director (or designee) in consultation with the Member, the terminated Participating Provider and, as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed twelve (12) months from the agreement's termination.

3. **Other Procedure:** An other procedure that has been authorized by PBHC or the Member's assigned Participating Provider as part of a documented course of treatment and had been recommended and documented by the terminated Participating Provider to occur within 180 calendar days of the agreement's termination date.

Copayments. Costs payable by the Member at the time Covered Services are received. Copayments may be a specific dollar amount or a percentage of covered charges as specified in this *Combined Evidence of Coverage and Disclosure Form* and are shown on the PBHC *Schedule of Benefits*.

Covered Services. Medically Necessary Behavioral Health Services provided pursuant to the *Group Subscriber Agreement*, this *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits* for Emergencies or those Behavioral Health Services, which have been pre-authorized by PBHC.

Custodial Care. Personal services required to assist the Member in meeting the requirements of daily living. Custodial Care is not covered under this PBHC Behavioral Health Plan. Such services include, without limitation, assistance in walking, getting in or out of bed, bathing, dressing, feeding, or using the lavatory, preparation of special diets and supervision of medication schedules. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

Customer Service Department. The department designated by PBHC to whom oral or written Member issues may be addressed. The Customer Service Department may be contacted by telephone at 1-800-999-9585 or in writing at:

PacificCare Behavioral Health of California, Inc.
Post Office Box 55307
Sherman Oaks, California 91413-0307

Day Treatment Center. A Participating Facility which provides a specific Behavioral Health Treatment Program on a full or part-day basis pursuant to a written Behavioral Health Treatment Plan approved and monitored by a PBHC Participating Practitioner and which is also licensed, certified, or approved to provide such services by the appropriate state agency.

Dependent. Any Member of a Subscriber's family who meets all the eligibility requirements set forth by the Employer Group under this PBHC Behavioral Health Plan and for whom applicable Plan Premiums are received by PBHC.

Diagnostic and Statistical Manual (or DSM-IV-TR). The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, which is published by the American Psychiatric Association and which contains the criteria for diagnosis of Chemical Dependency and Mental Disorders.

Domestic Partner is a person who meets the eligibility requirements, as defined by your Employer Group, and the following:

- (i) Is eighteen (18) years of age or older;
- (ii) Is mentally competent to consent to contract;
- (iii) Resides with the Subscriber and intends to do so indefinitely;
- (iv) Is jointly responsible with the Subscriber for their common welfare and financial obligations;
- (v) Is unmarried or not a member of another domestic partnership; and
- (vi) Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

Emergency or Emergency Services. A behavioral health condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the Prudent Layperson would expect the absence of immediate Behavioral Health Services to result in any

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of the following:

- Immediate harm to self or others;
- Placing one's health in serious jeopardy;
- Serious impairment of one's functioning; or
- Serious dysfunction of any bodily organ or part.

If you or your Dependent are experiencing a situation which requires Behavioral Health Services, and a delay in treatment from a PBHC Participating Provider would result in a serious deterioration to your health, the situation will be considered an Emergency.

Emergency Treatment. Medically Necessary ambulance and ambulance transport services provided through the "911" Emergency response system and medical screening, examination and evaluation by a Practitioner, to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if an Emergency for a Behavioral Health condition exists, and if it does, the care and treatment by a Practitioner necessary to relieve or eliminate the Emergency within the capabilities of the facility.

Employer Group. An employer, labor union, trust, organization, association, or other entity to which the PBHC *Group Subscriber Agreement* has been issued

Experimental and Investigational. Please refer to the "Experimental and Investigational Therapies" Section of this *Combined Evidence of Coverage and Disclosure Form*.

Family Member. The Subscriber's Spouse or Domestic Partner and any person related to the Subscriber or Spouse or Domestic Partner by blood, marriage, adoption or guardianship. An enrolled Family Member is a Family Member who is enrolled with PBHC, meets all the eligibility requirements of the Subscriber's Employer Group and PBHC, and for whom Premiums have been received by PBHC. An eligible Family Member is a family member who meets all the eligibility requirements of the Subscriber's Employer Group and PBHC.

Group Subscriber Agreement. The Agreement for the provision of Behavioral Health Services between

the Employer Group and PBHC.

Group Therapy. Goal-oriented Behavioral Health Services provided in a group setting (usually about 6 to 12 participants) by a PBHC Participating Practitioner. Group Therapy can be made available to the Member in lieu of individual outpatient therapy when pre-authorized by PBHC.

Inpatient Treatment Center. An acute care Participating Facility which provides Behavioral Health Services, under 24 hour nursing and medical supervision in an acute, inpatient setting, pursuant to a written Behavioral Health Treatment Plan approved and monitored by a PBHC Participating Practitioner and is licensed, certified, or approved as such by the appropriate state agency.

Limiting Age. The age established by the Employer Group when a Dependent is no longer eligible to be an enrolled Family Member under the Subscriber's coverage.

Maximum Benefit. The lifetime or annual maximum amount shown in the PBHC *Schedule of Benefits* which PBHC will pay for any authorized Behavioral Health Services provided to Members by PBHC Participating Providers.

Medical Detoxification. The medical treatment of withdrawal from alcohol, drug or other substance addiction, when pre-authorized by PBHC, is covered. In most cases of alcohol, drug or other substance abuse or toxicity, outpatient treatment is appropriate unless another medical condition requires treatment at an Inpatient Treatment Center.

Medically Necessary (or Medical Necessity). refers to an intervention, if, as recommended by the treating Practitioner and determined by the Medical Director of PBHC to be all of the following:

- a) A health intervention for the purpose of treating a Mental Disorder or Chemical Dependency;
- b) The most appropriate level of service or item, considering potential benefits and harms to the Member;
- c) Known to be effective in improving health



Section Ten In-Network Definitions

outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and

- d) If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. “Cost-effective” does not necessarily mean lowest price.

A service or item will be covered under the PBHC Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.

In applying the above definition of Medical Necessity, the following terms shall have the following meaning:

- (i) *Treating Practitioner* means a Practitioner who has personally evaluated the patient.
- (ii) A *health intervention* is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnose, detect, treat or palliate) a Mental Disorder or Chemical Dependency or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the Mental Disorder or Chemical Dependency condition and the patient indications for which it is being applied.
- (iii) *Effective* means that the intervention can reasonably be expected to produce the intended result and to have expected benefits that outweigh potential harmful effects.
- (iv) *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person’s life.
- (v) *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a

causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the Mental Disorder or Chemical Dependency condition or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of Medical Necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

- (vi) A *new intervention* is one that is not yet in widespread use for the Mental Disorder or Chemical Dependency and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.
- (vii) An intervention is considered *cost effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients

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In-Network Definitions



with this condition. The application of this criterion is to be on an individual case and the characteristics of the individual patient shall be determinative.

Member. The Subscriber or any Dependent, who is enrolled, covered and eligible for PBHC Behavioral Health Care coverage.

Mental Disorder. A mental or nervous condition diagnosed by a licensed Practitioner according to the criteria in the DSM-IV-TR resulting in the impairment of a Member's mental, emotional, or behavioral functioning.

Mental Health Services. Medically Necessary Behavioral Health Services for the treatment of Mental Disorders.

Non-Participating Providers. Licensed psychiatrists, psychologists, marriage and family therapists, licensed clinical social workers, and other behavioral health professionals, hospitals, and other licensed behavioral health facilities which provide Behavioral Health Services to eligible Members, but have not entered into a written agreement with PBHC to provide such services to Members.

Outpatient Treatment Center. A licensed or certified Participating Facility which provides a Behavioral Health Treatment Program in an outpatient setting.

Participating Facility. An Inpatient Treatment Center, Day Treatment Center, Outpatient Treatment Center or Residential Treatment Center which is duly licensed in the State of California to provide either acute inpatient treatment, day treatment, or outpatient care for the diagnosis and/or treatment of Mental Disorders and/or Chemical Dependency, and which has entered into a written agreement with PBHC.

Participating Practitioner. A psychiatrist, psychologist, or other allied behavioral health care professional who is qualified and duly licensed or certified to practice his or her profession under the laws of the State of California and who has entered into a written agreement with PBHC to provide Behavioral Health Services to Members.

Participating Providers. Participating Practitioners, Participating Preferred Group Practices and Participating Facilities, collectively, each of which has entered into a written agreement with PBHC to provide Behavioral Health Services to Members.

Participating Preferred Group Practice. A provider group or independent practice association duly organized and licensed under the laws of the State of California to provide Behavioral Health Services through agreements with individual behavioral health care providers, each of whom is qualified and appropriately licensed to practice his or her profession in the State of California.

PBHC Clinician. A person licensed as a psychiatrist, psychologist, clinical social worker, marriage, family and child therapist, nurse, or other licensed health care professional with appropriate training and experience in Behavioral Health Services, who is employed or under contract with PBHC to perform case management services.

Practitioner. A psychiatrist, psychologist or other allied behavioral health care professional who is qualified and duly licensed or certified to practice his or her profession under the laws of the State of California.

Premiums. The periodic, fixed-dollar amount payable to PBHC by the Employer Group for or on behalf of the Subscriber and the Subscriber's eligible Dependents in consideration of Behavioral Health Services provided under this Plan.

Residential Treatment Center. A residential facility that provides services in connection with the diagnosis and treatment of behavioral health conditions and which is licensed, certified, or approved as such by the appropriate state agency.

Schedule of Benefits. The schedule of Behavioral Health Services which is provided to Members under this Behavioral Health Plan. The *Schedule of Benefits* is attached and incorporated in full and made a part of this document.

Serious Emotional Disturbances of a Child (SED). A Serious Emotional Disturbance of a Child is defined



Section Ten In-Network Definitions

as a condition of a child who:

- 1) Has one or more Mental Disorders as defined by the Diagnostic and Statistical Manual (DSM-IV-TR), other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms; and
- 2) Is under the age of eighteen (18) years old.
- 3) Furthermore, the child must meet one or more of the following criteria:
 - a. As a result of the Mental Disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
 - (i) the child is at risk of removal from home or has already been removed from the home;
 - (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
 - b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder; or
 - c. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

Service Area. The geographic area in which PBHC is licensed to arrange for Behavioral Health Services in the State of California by the California Department of Managed Health Care.

Severe Mental Illness (SMI). Severe Mental Illness includes the diagnosis and treatment of the following conditions:

- Anorexia Nervosa
- Bipolar Disorder
- Bulimia Nervosa

Major Depressive Disorder

Obsessive-Compulsive Disorder

Panic Disorder

Pervasive Developmental Disorder, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism.

Schizoaffective Disorder

Schizophrenia

Spouse. The Subscriber's legally recognized husband or wife under the laws of the State of California.

Subscriber. The person whose employment or other status except for being a Family Member, is the basis for eligibility to enroll in the PBHC Behavioral Health Plan and who meets all the applicable eligibility requirements of the Group and PBHC, and for whom Plan Premiums have been received by PBHC.

Totally Disabled or Total Disability. The persistent inability to engage reliably in any substantially gainful activity by reason of any determinable physical or mental impairment resulting from an injury or illness. Totally Disabled is the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of a medically determinable physical or mental impairment resulting from an injury or illness. The disability must be related to a Behavioral Health condition, as defined in the DSM-IV-TR, in order to qualify for coverage under this PBHC Plan. Determination of Total Disability shall be made by a PBHC Participating Provider based upon a comprehensive psychiatric examination of the Member or upon the concurrence by a PBHC Medical Director, if on the basis of a comprehensive psychiatric examination by a non-PBHC Participating Provider.

Treatment Plan. A structured course of treatment authorized by a PBHC Clinician and for which a Member has been admitted to a Participating Facility, received Behavioral Health Services, and been discharged.

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In-Network Definitions



Urgent or Urgently Needed Services. Medically Necessary Behavioral Health Services received in an Urgent care facility or in a provider's office for an unforeseen condition to prevent serious deterioration of a Member's health resulting from an unforeseen illness or complication of an existing condition manifesting itself by acute symptoms of sufficient severity, such that treatment cannot be delayed.

Visit. An outpatient session with a PBHC Participating Practitioner conducted on an individual or group basis during which Behavioral Health Services are delivered.

NOTE: THIS *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM* CONSTITUTES ONLY A SUMMARY OF THE PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA (PBHC) PLAN. THE GROUP SUBSCRIBER AGREEMENT BETWEEN PBHC AND THE EMPLOYER GROUP MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A COPY OF THE GROUP SUBSCRIBER AGREEMENT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT PBHC AND YOUR EMPLOYER GROUP'S PERSONNEL OFFICE.

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY (PLHIC)



Part II

*Out-of-Network Benefit
Certificate of Coverage*

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY
3120 WEST LAKE CENTER DRIVE
Santa Ana, California 92704

BEHAVIORAL HEALTH CERTIFICATE OF INSURANCE

PacifiCare Life and Health Insurance Company (the "Company") hereby delivers to the Group Policyholder a Policy providing insurance for certain eligible Covered Persons. The *Certificate* describes the benefits and provisions of the insurance provided by the Policy.

You may receive the benefits specified in the *Certificate* if you are eligible for the insurance under the provisions.

The *Certificate* alone is not a contract of insurance and only summarizes the primary provisions of the Policy. The *Certificate* supersedes and replaces any similar certificate that the Company previously issued to you.

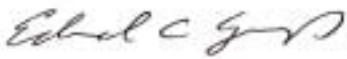
The *Certificate* is valid only if it includes your *Schedule of Benefits*.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW WHOM OR WHAT GROUP OF PROVIDERS BEHAVIORAL HEALTH CARE MAY BE OBTAINED.

YOUR OUT-OF-POCKET COSTS MAY BE LOWER WHEN USING OUT PARTICIPATING PROVIDERS. PLEASE CONSULT THE *SCHEDULE OF BENEFITS* FOR ADDITIONAL INFORMATION.

Provider Directories may be obtained from the Administrator.

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY



Edward C. Cymerys, President

ADMINISTRATOR

The Company's Administrator administers the provisions of this *Certificate*. It is as follows:

FOR PAYMENT OF CLAIMS, ELIGIBILITY, AND BENEFITS VERIFICATION

PacifiCare Behavioral Health, Inc.

P.O. Box 31053

Laguna Hills, California 92654-1054

Or visit the PBH website: www.pbhi.com

Customer Service

1-800-999-9585

1-888-877-5378 (TDHI)]

24 hours a day, seven days a week

All inquiries and notifications required by the terms and conditions of the Policy are to be mailed or telephoned to the Company's Administrator as indicated above.



Section One

Out-of-Network Covered Services

Out-of-Network Covered Services

- *Out-of-Network Covered Services*
- *Out-of-Network Limitation of Benefits and Exclusions*

This section explains your Out-of-Network behavioral health benefits, including what is and is not covered by the Company. If you incur Covered Expenses for Chemical Dependency or Mental Disorders, the Company will pay benefits as determined below and in accordance with the Out-of-Network portion of the *Schedule of Benefits*. If a specific service or supply is not included in this Section One, it is not a Covered Service and no benefit will be provided under the Policy.

Out-of-Network Covered Services

The Company will pay for the following Out-of-Network Behavioral Health Services furnished in connection with the treatment of Mental Disorders and/or Chemical Dependency as outlined in the *Schedule of Benefits*. Refer to the Out-of-Network Limitation of Benefits and Exclusions section to determine specific coverage. All Out-of-Network Behavioral Health Services must be received while coverage is in effect and the Covered Person is eligible for coverage.

I. Mental Health Services:

Outpatient Practitioner Care – The Company provides coverage for Outpatient Mental Health Services Visits. All Behavioral Health Services provided for the treatment of Serious Mental Illness and Serious Emotional Disturbance of a Child as defined in the Section Five “Definitions” of this *Certificate*, are not covered under this Out-of-Network behavioral health plan only to the benefit maximums. These services are covered at the parity levels as mandated under California Health and Safety Code Section 1374.2 under your In-Network behavioral health plan only.

II. Chemical Dependency Services

Outpatient Practitioner Care – The Company provides coverage for Chemical Dependency Treatment Programs.

III. Other Behavioral Health Services

Diagnostic Services – The Company provides diagnostic and treatment services, including consultation and treatment.

Out-of-Network Limitations of Benefits and Exclusions

Unless described as a Covered Service in an attached supplemental Benefit Rider, all services and benefits described below are either limited or excluded from coverage under this Out-of-Network behavioral health plan.

1. Behavioral Health Services provided for an Emergency Services are not covered under this Out of Network behavioral health plan
2. Behavioral Health Services provided for the treatment of Severe Mental Illness and Serious Emotional Disturbance of a Child as defined in this *Certificate* are not covered under this Out-of-Network behavioral health plan.
3. All services not specifically included in this *Certificate* or the *Schedule of Benefits* included with this Certificate are not covered.
4. Services rendered prior to the Covered Person's effective date of enrollment, after the effective date of disenrollment are not covered.
5. Services payable under workers' compensation are not covered.
6. Any services that the Covered Person receives from a local, state or federal government agency are not covered.
7. Speech therapy, physical therapy and occupational therapy services provided in connection with the treatment of psychosocial speech delay, learning disorders, including mental retardation and motor

Section One

Out-of-Network Covered Services



- skill disorders, and educational speech delay including delayed language development are not covered.
8. Treatments which do not meet national standards for mental health professional practice are not covered.
 9. Routine, custodial, and convalescent care, long term therapy and/or rehabilitation are not covered.
 10. Any services provided by non-licensed Providers are not covered.
 11. Pastoral or spiritual counseling are not covered.
 12. Dance, poetry, music or art therapy services except as part of a Behavioral Health Treatment Program are not covered.
 13. School counseling and support services, home based behavioral management, household management training, peer support services, recreation, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, wraparound services, Emergency aid to household items and expenses, and services to improve economic stability and interpretation services are not covered.
 14. Genetic counseling services are not covered.
 15. Community Care Facilities that provide 24-hour non-medical residential care are not covered.
 16. Weight control programs, eating disorder programs and treatment for addictions to tobacco, nicotine or food are not covered.
 17. Counseling for adoption, custody, family planning or pregnancy in the absence of a DSM-IV-TR diagnosis are not covered.
 18. Counseling, treatment or services associated with or in preparation for a sex (gender) reassignment operation are not covered.
 19. Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence are not covered.
 20. Personal or comfort items, and private room and/or private duty nursing during inpatient hospitalization are not covered.
 21. All non-prescription and prescription drugs, which are prescribed during the course of outpatient treatment, are not covered. Outpatient prescription drugs may be covered under your medical plan.
 22. Outpatient Surgery - short-stay, same day or other similar Outpatient surgery services are not covered.
 23. Acupuncture and Acupressure are not covered.
 24. Services required for illness experienced while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state or local laws are not covered.
 25. Neurological services and tests, including, but not limited to, EEGs, Pet scans, beam scans, MRI's, skull x-rays and lumbar punctures are not covered.
 26. Treatment sessions by telephone or computer Internet services are not covered.
 27. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations, or career counseling are not covered.
 28. Educational services to treat developmental disorders, developmental delays or learning disabilities are not covered. A learning disability is a condition where there is a meaningful difference between a child's current academic level of function and the level that would be expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading and psychological and visual integration training as defined by the American Academy of Pediatrics Policy Statement - Learning Disabilities, Dyslexia and Vision: A Subject Review.
 29. Treatment of problems that are not Mental Disorders are not covered, except for diagnostic evaluation.
 30. Mental Health Services rendered at a Residential Treatment Center or other facilities or institutions



Section One

Out-of-Network Covered Services

that are not Inpatient Treatment Centers.

31. Methadone maintenance treatment is not covered.
32. All Inpatient services are not covered. All Medically Necessary Inpatient benefits are covered under your In-Network behavioral health plan only.
33. Behavioral Health Services, which are indicated as not, covered on the *Schedule of Benefits*.
34. Behavioral Health Services provided for the treatment of autism are not covered.
35. Medical Detoxification programs are not covered. These services are covered under your medical plan.

Section Two

Out-of-Network Payment Responsibility



Out-of-Network Payment Responsibility

- *Claims Policies and Procedures*
- *Coordination of Benefits*

This section explains Claims payment procedures and related Claims matters. It also explains when the Company needs to coordinate your benefits with another plan.

Claims Policies and Procedures

These procedures must be followed by Covered Persons to obtain payment of benefits under the Policy.

Limitation of Liability

The Company shall not be obligated to pay any benefits under the Policy for any Claims if the proof of loss for such Claim was not submitted within the period provided, unless it is shown that (a) it was not reasonably possible to have submitted the proof of loss within such period and (b) the proof of loss was submitted as soon as it was reasonably possible.

In no event will the Company be obligated to pay benefits for any Claim if the proof of loss for such Claim is not submitted to the Company within 1 year after the date of loss, except in the case of legal incapacity of the Covered Person.

Claims Processing

The Company reviews and evaluates all service benefit payment submissions for the possibility of billing irregularities. The Company may adjust or decline benefit payments consistent with the evaluation findings.

Notice of Claim

A written notice of Claim must be furnished to the Company within 20 days after a covered loss occurs or begins, or as soon thereafter as reasonably possible.

The Company will, upon receipt of notice of Claim,

furnish to the Insured Person such forms as are usually furnished for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, the Insured Person shall be deemed to have complied with the requirements of the Policy as to the proof of loss upon submitting within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which a Claim is made.

Proof of Loss

Written proof of loss must be furnished to the Company at its office within 90 days after the date of the loss. The Company will not reduce or deny a Claim for failure to furnish such proof within the time required, provided such proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, the Company will not accept proof more than 1 year from the time proof is otherwise required.

Time of Payment of Claims

Benefits for incurred medical expenses that are covered under the Policy will be paid upon receipt of a proper Claim by the Company.

Payment of Benefits to Insured Person

All benefits, unless assigned under the Policy, are payable to the Insured Person, whose sickness, or whose covered Dependent's sickness, is the basis of a Claim.

Death or Incapacity of Insured Person

In the event of the Insured Person's death or incapacity and in the absence of written evidence to the Company of the qualification of a guardian for the Insured Person's estate, the Company may, in its sole discretion make any and all payments of benefits under the Policy to the individual or institution that, in the opinion of the Company, is or was providing the Insured Person's care and support.

Assignments

Benefits for Covered Expenses may be assigned by the Covered Person to the person or institution rendering the services. No such assignment will bind the Company



Section Two

Out-of-Network Payment Responsibility

prior to the payment of the benefits assigned. The Company will not be responsible for determining an assignment's validity. Payment of assigned benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person and the assignee, is received prior to payment.

Legal Actions

Any Covered Person may not bring legal action for benefits against the Company:

1. Until at least 60 days after proof of loss is sent to the Company as required; or
2. More than 3 years after the time for submitting proof has ended.

Physical Examinations

The Company, at its expense, may:

1. have a Covered Person examined, as often as reasonably necessary, while any Claim is pending; and
2. have an autopsy made, where allowed by law, if a Claim for benefits is made.

Coordination of Benefits

The Company may coordinate benefits with benefits available under other similar Behavioral Health Services insurance policies. Coordination of Benefits between policies may result in a reduction in the amount of benefits ordinarily payable, so that the Covered Person never receives a total, from all Plans, of more than 100% of Covered Expense incurred. All benefits provided under the Policy are subject to this coordination provision.

What is a Plan?

A "Plan", as used in this Coordination of Benefits provision, means any of the following policies that provide benefits or services for medical or surgical treatment:

1. group, blanket or franchise insurance coverage;
2. prepaid coverage under service Plan contracts, or under group or individual practice;

3. any coverage under labor-management trustee plans, union welfare plans, Employer organization Plans, or employee benefit organizations Plans;
4. any coverage in group, group-type and individual automobile "no-fault" and traditional automobile "fault" type plans;
5. Medicare or other governmental benefits, not including a state plan under Medicaid, and not including a Plan when, by law, its benefits are in excess to those of any private insurance Plan or other non-governmental Plan; or
6. any coverage under group-type contracts that is not available to the public and can only be obtained and maintained because of Covered Person in or association with a particular organization or group.

Each Plan, or other arrangement for coverage described above, is a separate Plan. If a Plan has two parts and the coordination of benefits provisions only apply to one part, each part is a separate Plan. However, if separate contracts are used to provide coordinated coverage for Covered Persons of a group, the separate contracts are considered parts of the same Plan and there is no Coordination of Benefits between those separate contracts.

What is a Covered Expense?

A Covered Expense, as used in this Coordination of Benefits provision, means any expense which is covered by at least one Plan during a Claims Determination Period; however, any expense which is not payable by the primary Plan because of the claimant's failure to comply with cost-containment requirements will not be considered a Covered Expense by the secondary Plan. Where a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Calendar Year will also be considered a Covered Expense.

Order of Benefit Determination Rules

The following rules determine the order of benefit payment:

1. A Plan without a Coordination of Benefits provi-

Section Two

Out-of-Network Payment Responsibility



sion pays before one with such a provision;

2. A Plan which covers a person other than as a Dependent pays before a Plan which covers a person as a Dependent;
3. For a covered Dependent child, the Plan of the parent whose date of birth, excluding year of birth, occurs earlier in a Calendar Year pays before the Plan of the parent whose date of birth, excluding year of birth, occurs later in a Calendar Year. To apply, the coordinating Plan must have a similar provision; and
4. If two or more Plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. first, the Plan of the parent with custody of the child;
 - b. then, the plan of the Spouse or Domestic Partner of the parent with custody of the Dependent child; and
 - c. finally, the Plan of the parent without custody of the child.

However, where a court decree orders one parent responsible for the Behavioral Health Services expenses of the child, the Plan of that parent pays first.

5. When rules 1. through 4. do not establish the order of benefit determination, the Plan covering the Person for a longer period pays first; however:
 - a. the Plan covering the person as a laid-off or retired employee, or as a Dependent of a laid-off or retired employee, will pay after any other Plan covering that person as a full-time employee, or Dependent of a full-time employee; and
 - b. if the other Plan does not have an Order of Benefit Determination Rule regarding laid-off or retired employees, then the provisions of rule 5.a. will not apply.

Effect on Benefits

Benefits will be reduced when the Policy is secondary to one or more other Plans. Benefits will be reduced

when the sum of:

1. the benefits payable for the Covered Expense under this Plan without this provision; and
2. the benefits payable for the Covered Expense under the other Plans, without this provision, whether or not a Claim is made, exceed the Covered Expense in a Calendar Year. Thereafter, benefits will be reduced so that coordination with benefits payable under the other Plans do not total more than the Covered Expense.

Right to Receive and Release Information

For determining the applicability and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other Plan, the Company may release or obtain from any insurance Company or other organization or person any information, with respect to any Covered Person, which the Plan deems to be necessary for such purposes. Any Covered Person claiming benefits must furnish information necessary to implement this provision.

Reimbursement of Payment

Payments made by any organization may be reimbursed by the Company subject to Policy limitations. Such reimbursements will fully discharge the Company's liability under the Policy.

Right of Recovery

Whenever payments for Covered Expenses exceed the maximum payment necessary to satisfy the Coordination of Benefits provisions, the Company may recover such excess payments. The term "payments for Covered Expenses" includes the reasonable cash value of any benefits provided in the form of services.

Third Party Liability and Non-duplication of Benefits

1. **Third Party Liability.** This provision applies when:



Section Two

Out-of-Network Payment Responsibility

- a. A Covered Person suffers an injury or sickness through the act or omission of another person (the “Third Party”); and
- b. Benefits are paid under the Policy for that injury or sickness.

The Company is entitled to a refund of all benefits paid. The refund must equal the payment for the injury or sickness by the Third Party. The Company may file a lien against the Third Party payment. The Covered Person must complete and return any required forms to the Company upon request.

The Covered Person agrees that the Company’s rights to reimbursement under the Coordination of Benefits section are the first priority Claim against any Third Party. The Company shall be reimbursed from any recovery before payment of any other existing Claims, including any Claim by the Covered Person for general damages. The Company may collect from the proceeds of any settlement or judgment recovered by the Covered Person, or his or her legal representative, regardless of whether the Covered Person is fully compensated.

The Covered Person agrees to cooperate in protecting the interests of the Company. The Covered Person must execute and deliver to the Company any and all liens, assignments or other documents necessary to fully protect the right of the Company, including, but not limited to, the granting of a lien right in any Claim or action made or filed on behalf of the Covered Person. The Covered Person’s failure to cooperate with the Company may result in such Covered Person’s termination under the Policy.

The Covered Person shall not settle any Claim, or release any person from liability, without the written consent of the Company, if such release or settlement extinguishes or bars the Company’s rights of reimbursement.

In the event the Company employs an attorney for the purpose of enforcing any part of this section against a Covered Person, based on the Covered Person’s failure to cooperate with the Company, the

prevailing party in any legal action or proceeding shall be entitled to reasonable attorneys’ fees.

In lieu of payment as indicated above, the Company, at its option, may choose to be subrogated to the Covered Person’s rights to the extent of the benefits received under the Policy. The Company’s subrogation right shall include the right to bring suit in the Covered Person’s name. The Covered Person shall fully cooperate with the Company when the Company exercises its right of subrogation and the Covered Person shall not take any action or refuse to take any action which should prejudice the rights of the Company under this section.

2. Non-Duplication of Benefits

- a. **Workers’ Compensation.** The Company shall not furnish benefits under the Policy to any Covered Persons, which duplicate benefits the Covered Person is entitled to under any Workers’ Compensation law.

In the event of a dispute regarding the Covered Person’s receipt of benefits under Workers’ Compensation laws, the Company will provide the benefits described in the Policy until resolution of the dispute.

In the event the Company provides benefits which duplicate the benefits the Covered Person is entitled to under Workers’ Compensation law, the Covered Person agrees to reimburse the Company, for all such benefits provided by the Company, immediately upon obtaining any monetary recovery. The Covered Person shall hold any sum collected as the result of a Workers’ Compensation action in trust for the Company. Such sum shall equal the lesser of the amount of the recovery obtained by the Covered Person or the benefits furnished to the Covered Person by the Company on account of each incident.

The Covered Person agrees to cooperate in protecting the interests of the Company under this provision. The Covered Person must

Section Two

Out-of-Network Payment Responsibility



execute and deliver to the Company any and all liens, assignments or other documents necessary to fully protect the right of the Company, including, but not limited to, the granting of a lien right in any Claim or action made or filed on behalf of the Covered Person.

- b. Medicare Benefits.** The Covered Person shall furnish information to the Company upon request concerning eligibility for Medicare (Part A and/or Part B coverage). In those instances set forth in the “Medicare is Primary” section below, the Company shall not furnish benefits under the Policy which duplicate the benefits the Covered Person is entitled to as a Medicare beneficiary, regardless of whether or not the Covered Person actually enrolled in Medicare. Should the cost of medical or Hospital services exceed Medicare coverage, the Company benefits shall be provided over and above such coverage.

If payment is made by the Company in duplication of the benefits available to the Covered Person as a Medicare beneficiary, as set forth in the “Medicare is Primary” section below, the Company may seek reimbursement from the insurance carrier, Provider, or Covered Person up to the amount of benefits which duplicate Medicare benefits.

- c. The Company is Primary.** In the following instances, the Company will provide benefits to Covered Persons with Medicare coverage, and Medicare will be responsible for payment only to the extent of services not covered under the Policy:
- 1) Aged employees: Insured Persons who are Actively At Work and are age 65 or older, or any Dependent age 65 or older.
 - 2) Disabled employees: Covered Persons eligible for Medicare as a result of a disability if Covered Persons are enrolled through an Employer that has 100 or more Full-time Employees; and

- d. Medicare is Primary.** The Company’s coverage will be limited to the cost of Covered Services not covered by Medicare for a Covered Person who meet the following definition of Medicare Retiree: a Covered Person who is: a) eligible for Medicare Part A and/or Part B (whether or not enrollment in Medicare actually occurs); b) eligible for retiree coverage provided by the Group Policyholder; and c) properly enrolled under the Policy.

- e. TRICARE Benefits.** The Covered Person shall furnish, upon request from the Company, information concerning any applicable benefits from the TRICARE, which the Covered Person may be entitled to receive. The Company shall not furnish benefits under the Policy which duplicate the benefits to which the Covered Person is entitled under TRICARE.

If payment is made by the Company, in duplication of the benefits available under TRICARE, the Company may seek reimbursement up to the amount of benefits which duplicate such benefits under TRICARE.

- f. Automobile, Accident or Liability Coverage.** The Company shall not furnish benefits which duplicate benefits the Covered Person is entitled to under any automobile, accident or liability coverage. The Covered Person is responsible for taking whatever action necessary to obtain the available benefits of such coverage, and will notify the Company of receipt of such available benefits. If payment is provided by the Company in duplication of the benefits under other automobile, accident or liability coverage, the Company may seek reimbursement for the duplicate benefits.

Should the cost of Covered Services exceed the benefits under any other liability coverage pursuant to this section, the Policy benefits will be provided over and above such liability coverage.



Out-of-Network Covered Person Eligibility

- *Who is a Covered Person?*
- *Adding Dependents*
- *Late Enrollment*
- *Updating Your Enrollment*
- *Termination of Benefits*

This section describes how you become eligible to use the Out-of-Network behavioral health benefits. In addition, you will learn ways you may be able to extend your coverage when it would otherwise terminate.

Who is a Covered Person?

There are two kinds of Covered Persons: the Insured Person who enrolls in the Policy through his or her Employer and his or her eligible Dependents. The Employer, in turn, has signed a Policy with the Company.

The following Dependents are eligible to enroll in the Policy:

1. The Insured Person's Spouse or Domestic Partner who is not legally separated;
2. The unmarried biological children of the Insured Person, the Insured Person's Spouse or Insured Person's Domestic Partner's (stepchildren) who are under age 19 or as determined by the Company;
3. Unmarried children who are legally adopted or placed for adoption with the Insured Person, the Insured Person's Spouse or the Insured Person's Domestic Partner who are under age 19 as determined by the Company;
4. The unmarried biological children of the Insured Person, the Insured Person's Spouse or the Insured Person's Domestic Partner (stepchildren) who are age 19 or older but under age 25 as determined by

the Company, and who are full-time students at an accredited college or university;

5. Children for whom the Insured Person, the Insured Person's Spouse or the Insured Person's Domestic Partner has assumed permanent legal guardianship. Legal evidence of the guardianship, such as a certified copy of a court order, must be furnished to The Company upon request;
6. Children for whom the Insured Person, the Insured Person's Spouse or the Insured Person's Domestic Partner is required to provide health insurance coverage pursuant to a qualified medical child support order assignment order, or medical support order, in this section; and
7. Unmarried children meeting all of the following conditions:
 - a. totally and permanently disabled and unable to earn a living (proof of such disability must be submitted to the Company within 30 days of the date coverage would have ended due to the child's age);
 - b. dependent on the Insured Person for principal economic support; and
 - c. covered under the Policy on a day prior to the day coverage would have ended due to the child's age.

At any time, the Company may require proof that a child continues to qualify as a Dependent. In addition to natural children, legally adopted children, and a child the Insured Person is seeking to adopt, the word "child" includes an Insured Person's stepchild if the child:

1. resides in the Insured Person's household; and
2. is dependent on the Insured Person for principal economic support.

The term Dependent does not include any person serving in the armed forces of any country.

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Out-of-Network Covered Person Eligibility



If a husband and wife or Domestic Partner are Insured Persons, their Dependents, if any, may be considered as Dependents of either the husband or wife/Domestic Partner, but not of both. A Covered Person may either be an Insured Person or a Dependent of an Insured Person, but not both at the same time.

Eligibility

The Company's eligibility requirements are:

Insured Person

A Person becomes eligible for the coverage provided by the Policy on the latest of the following dates:

1. the Policy Effective Date;
2. the effective date of coverage for the Employer; or
3. the date the Insured Person completes the Waiting Period as a Full-time Employee.

Dependent

Each Dependent of an Insured Person becomes eligible for Dependent Insurance provided by the Policy on the later of:

1. the date the Insured Person becomes eligible for personal insurance; and
2. the date the Insured Person first acquires the Dependent.

Eligible Dependents must enroll at the same time as the Insured Person or risk not being eligible to enroll until the Employer's next Open Enrollment Period, as explained below. Circumstances, which allow for enrollment outside the Open Enrollment Period are also explained below. All applicants for coverage must complete and submit to the Company all applications, medical review questionnaires or other forms or statements that the Company may reasonably request.

Enrollment is the completion of a Company enrollment form (or a nonstandard enrollment form approved by the Company) by the Insured Person on his or her own behalf or on the behalf of any eligible Dependent. Enrollment is conditional upon acceptance by the Company; the existence of a valid Employer

Policy; and the timely payment of applicable behavioral health plan Premiums. The Company may in its discretion and subject to specific protocols, accept enrollment data through an electronic submission.

The effective date of enrollment under the Policy will depend on when and how the Covered Person enrolls. These circumstances are explained below.

Open Enrollment

Most Covered Persons enroll in the Policy during the Open Enrollment Period established by the Employer. This is the period of time established by the Employer when its eligible employees and their eligible Dependents may enroll in the Employer's Behavioral Health Services benefit plan. An Open Enrollment Period usually occurs once a year, and enrollment is effective based on a date agreed upon by the Employer and the Company.

Adding Dependents to Insured Person's Coverage

The Insured Person's Spouse and eligible children may apply for coverage with the Company during the Employer's Open Enrollment Period. If the employee declines enrollment or for his or her Dependents (including a Spouse) because of other health plan or insurance coverage, the employee may in the future be able to enroll him or her self or his or her Dependents, provided that enrollment is requested within 30 days after other coverage ends. In addition, if an employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, he or she may enroll him or her self and his or her Dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption. (Guardianship is not a qualifying event for other Dependents to enroll). Please note that you may be asked to provide a marriage certificate, affidavit of domestic partnership, birth certificate or legal adoption paperwork if the event occurs outside of the Open Enrollment Period. Under the following circum-



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Out-of-Network Covered Person Eligibility

stances, new Dependents may be added outside the Open Enrollment Period.

1. **Getting married.** When a new Spouse or child becomes an eligible Dependent as a result of marriage, coverage begins on the first day of the month following the date of marriage. An application to enroll a Spouse or child eligible as a result of marriage must be made within 30 days of the marriage.
2. **Domestic Partnership.** When a new Domestic Partner or Domestic Partner's child becomes an eligible Family Member as a result of a domestic partnership, coverage begins on the first day of the month following the date of the domestic partnership. An application to enroll a Domestic Partner or child eligible as a result of a domestic partnership must be made within 30 days of the domestic partnership.
3. **Having a baby.** Newborns are covered for the first 30 days of life. In order for coverage to continue beyond the first 30 days of life, the Insured Person must submit a change request form to the Company prior to the expiration of the 30-day period for coverage to continue beyond the first 30 days of life.
4. **Adoption or Placement for Adoption.** Receive an adoptive placement from a recognized county or private agency, or adopted as documented by a health Facility minor release form, a medical authorization form or a relinquishment form, granting Insured Person, his or her Spouse or Domestic Partner the right to control the health care for the adoptive child or absent such a document, on the date there exists evidence of the Insured Person's, Spouse's or Domestic Partner's right to control the health care of the child placed for adoption. For adopted children, coverage is effective on the date of adoption or placement for adoption. An application must be received within 30 days of the adoption placement.
5. **Guardianship.** To enroll a Dependent child for whom the Insured Person has assumed legal

guardianship, the Insured Person must submit a change request form to the Company along with a certified copy of a court order granting guardianship within 30 days of when the Insured Person assumed legal guardianship. Coverage will be retroactively effective to the date the Insured Person assumed legal guardianship.

6. **Qualified Medical Child Support Order.** A Covered Person (or an employee otherwise eligible to enroll in the Company) may enroll a child who is eligible to enroll in the Policy upon presentation of a request by a district attorney, State Department of Health Services or a court order to provide medical support for such a dependent child without regard to any enrollment period restrictions.

A person having legal custody of a child or a custodial parent who is not a Covered Person may ask about obtaining Dependent coverage as required by a court or administrative order, including a qualified medical child support order, by calling the Company's Customer Service department.

Continuing Coverage for Student and Disabled Dependents

Certain Dependents who would otherwise lose coverage under the Policy due to their attainment of the Limiting Age established by the Company may extend their coverage under the following circumstances:

Continuing Coverage for Student Dependents

An unmarried Dependent who is registered on a full-time basis (at least 12 semester units or the equivalent as determined by the Company) at an accredited school or college may continue as an Eligible Dependent through the Limiting Age established by the Company for full-time students, if proof of such status is provided to the Company on a periodic basis.

Coverage for Certain Disabled Dependents

Unmarried enrolled Dependents, who attain the Limiting Age established by the Company, may continue enrollment in the Policy beyond the Limiting Age if the

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Out-of-Network Covered Person Eligibility



unmarried Dependent meets all of the following:

1. The unmarried Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap;
2. The unmarried Dependent is chiefly dependent upon the Insured Person for support and maintenance; and
3. The mental or physical condition existed continuously prior to reaching the Limiting Age.

In order to continue coverage under this section for qualifying disabled Dependents, proof of such disability and dependency must be provided to the Company by the Covered Person within 31 days of the onset of the disability, attainment of the Limiting Age or at the time of the Insured Person's initial enrollment in the Policy.

The Company may require ongoing proof of a Dependent's disability and dependency, but not more frequently than annually after the two-year period following the Dependent's attainment of the Limiting Age. This proof may include supporting documentation from a state or federal agency or a written statement by a licensed psychologist, psychiatrist or other Physician to the effect that such disabled Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap.

Late Enrollment

In addition to a Special Enrollment Period due to the addition of a new Spouse or child, there are certain circumstances when employees and their eligible Dependents may enroll outside of the Employer's Open Enrollment Period. These circumstances include:

1. The eligible employee (on his or her own behalf, or on behalf of any eligible Dependents) declined in writing to enroll in the Company when they were first eligible because they had other behavioral health care coverage, and
2. The Company cannot produce a written declination statement from the Group Policyholder or eli-

gible employee stating that the eligible employee (on his or her own behalf, or on behalf of any eligible Dependents) was provided with and a signed acknowledgment of explicit written notice in boldface type specifying that failure to elect coverage with The Company during the initial enrollment period permits the plan to impose an exclusion of coverage under the behavioral health plan for a period of 12 months from the date of election of coverage under the behavioral health plan, unless the eligible employee or Dependent can demonstrate that he or she meets the requirements for late enrollment.

3. The other behavioral health care coverage is no longer available due to:
 - i. The employee or eligible Dependent has exhausted COBRA continuation coverage under another group behavioral health plan; or
 - ii. The termination of employment or reduction in work hours of a Insured Person through whom the employee or eligible Dependent was covered; or
 - iii. The termination of the other behavioral health plan coverage; or
 - iv. The cessation of an Employer's contribution toward the employee or eligible Dependent coverage; or
 - v. The death, divorce or legal separation of a Insured Person through whom the employee or eligible Dependent was covered.
4. The Court has ordered behavioral health care coverage be provided for a Spouse or minor child.

If the employee or an eligible Dependent meets these conditions, the employee must request enrollment with the Company no later than 30 days following the termination of the other behavioral health plan coverage. The Company may require proof of loss of the other coverage. Enrollment will be effective the first day of the calendar month following receipt by the Company of a completed request for enrollment.



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Effective Date

In the event an employee or Dependent who is eligible for coverage under the Policy declines enrollment for such coverage during an Open Enrollment Period or within 31 days of becoming eligible, and subsequently requests enrollment, Personal Insurance or Dependent Insurance will become effective on the first day of the Insurance Month following the end of the next Open Enrollment Period after the date on which the Insured Person enrolled, unless the Insured Person or Dependent is eligible for Special Enrollment Period.

Exception to Effective Date

If an Insured Person's coverage terminates due to an approved leave of absence or military leave, the Company will waive any Waiting Period upon the Insured Person's return; provided:

- a. the Insured Person returns within six months after the leave of absence or military service begins; and
- b. the Insured Person applies or is enrolled within 31 days after resuming Active Work.

Updating Enrollment Information

The Employer must be notified of any changes to the information provided on the enrollment Application within 31 days of the change. This includes changes to a name, address, telephone number, marital status or the status of any enrolled Dependent.

Ending Coverage (Termination of Benefits)

Usually, enrollment in the Policy terminates when the Insured Person or enrolled Dependent is no longer eligible for coverage under the Employer's behavioral health benefit plan. In most instances, the Employer determines the date in which coverage will terminate. Coverage can be terminated, however, because of other circumstances as well, which are described below.

Continuing coverage under this behavioral health benefit plan is subject to the terms and conditions of the Employer's Policy with the Company.

When the Policy between the Employer and the Company is terminated, all Covered Persons under the Policy become ineligible for coverage on the date of termination. If the Policy is terminated by the Company for nonpayment of Premiums, coverage for all Covered Persons under the Policy will be terminated effective the last day for which Premiums were received. According to the terms of the Policy, the Group Policyholder is responsible for notifying the Insured Person if and when the Policy is terminated for any reason, including the nonpayment of Premiums. The Company is not obligated to notify a Covered Person that he or she is no longer eligible or that coverage has been terminated.

In addition to terminating the Policy, the Company may terminate a Covered Person's coverage if he or she no longer meets the eligibility requirements established by the Group Policyholder and/or the Company.

Termination for Good Cause:

The Company has the right to terminate coverage under this Policy in the following situations:

1. the Insured Person's personal insurance terminates;
 2. Dependent insurance is discontinued under the Policy;
 3. the Insured Person ceases to be eligible for Dependent insurance;
 4. the Insured Person requests that the Dependent insurance be terminated; or
 5. the last day of the Premium paying period for which the Insured Person has made any required contribution toward the cost of the Dependent insurance.
- Dependent Insurance will cease on the date such person ceases to be a Dependent as defined in the Policy. However, coverage for a dependent child enrolled hereunder by a court or administrative order to provide behavioral health insurance coverage for the child will not terminate unless the Company or Employer receives satisfactory written evidence that:
 - a. the court order or administrative order is no longer in effect or is legally terminated; or

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- b. through another insurer, the Dependent child is or will be enrolled in comparable behavioral health insurance that will take effect not later than the effective date of the Dependent child's disenrollment.

Fraud or Misrepresentation. Coverage may be terminated if false information is knowingly provided (or a meaningful fact is misrepresented) on the signed enrollment form or if a Covered Person fraudulently or deceptively uses services or facilities services provided under the Policy (or knowingly allows another person to do the same), including altering a prescription. Termination is effective immediately on the date the Company mails the notice of termination, unless the Company has specified a later date in that notice.

If coverage is terminated for any of the above reasons, the Covered Person forfeits all rights to enroll in the Company conversion plan (discussed below) or COBRA plan and lose the right to re-enroll in the Company's behavioral health plan in the future. Under no circumstances will a Covered Person be terminated due to behavioral health status or the need for behavioral health care services. If a Covered Person is Totally Disabled when the Group Policyholder's coverage ends, coverage for the Totally Disabling condition may be extended (please refer below to "Total Disability").

NOTE: If a Policy is terminated by the Company, reinstatement with the Company is subject to all terms and conditions of the Policy between the Company and the Employer.

Ending Coverage: Special Circumstances for Enrolled Dependents: Enrolled Dependents terminate on the same date of termination as the Insured Person. If there's a divorce, the Spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered unless a qualified court order is presented to the Company requesting eligibility not end. Dependent children lose their eligibility if they marry or reach the Limiting Age established by the Company and do not qualify for extended coverage as a student Dependent or as a disabled Dependent. Please refer to the section "Continuing Coverage for Certain

Disabled Dependents." It may also end when a qualified student reaches the Limiting Age.

Total Disability

If a Covered Person is Totally Disabled at the time his or her coverage ends, coverage for such Total Disability will be extended for injury or sickness causing the Total Disability. This extension will end on the earliest of the following:

1. the date such Covered Person is no longer Totally Disabled;
2. 12 months from the date his or her coverage under the Policy would otherwise have terminated; or
3. the date such Covered Person acquires coverage under a replacement behavioral health plan that provides similar benefits, but only if such plan covers the injury or sickness causing the Total Disability without limitation due to the injury or sickness having begun prior to the effective date of the replacement behavioral health coverage.

Coverage Options Following Termination Individual Continuation of Benefits

If your coverage through this *Certificate* ends, you and your enrolled Dependent may be eligible for additional continuation coverage.

Federal COBRA Continuation Coverage

If the Insured Person's Employer is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), Covered Persons may be entitled to temporarily extend coverage under the behavioral health plan at group rates, plus an administration fee, in certain instances where coverage under the behavioral health plan would otherwise end. This discussion is intended to inform Covered Persons, in a summary fashion, of the rights and obligations under COBRA. However, the Employer is legally responsible for informing Insured Persons of the specific rights under COBRA. Therefore, please consult with the Employer regarding the availability and duration of



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COBRA continuation coverage.

Insured Persons covered by this behavioral health plan have a right to choose COBRA continuation coverage if group behavioral health coverage is lost because of the termination of employment (for reasons other than gross misconduct the part of the Insured Person) or the reduction of hours of employment to less than the number of hours required for eligibility.

The Spouse of an Insured Person covered by this behavioral health plan has the right to choose COBRA continuation coverage if group behavioral health coverage under this behavioral health plan is lost for any of the following four reasons:

1. The death of Insured Person Spouse;
2. A termination of the Insured Person Spouse's employment (for reasons other than gross misconduct) or reduction in the Insured Person Spouse's hours of employment to less than the number of hours required for eligibility;
3. Divorce or legal separation from the Insured Person Spouse; or
4. The Insured Person Spouse becomes entitled to Medicare

In the case of a Dependent child of an Insured Person enrolled in this behavioral health plan, he or she has the right to continuation coverage if group behavioral health coverage under this behavioral health plan is lost for any of the following five reasons:

1. The death of the Insured Person;
2. A termination of the Insured Person's employment (for reasons other than gross misconduct) or reduction in the Insured Person's hours of employment to less than the number of hours required for eligibility;
3. The Insured Person's divorce or legal separation;
4. The Insured Person becomes entitled to Medicare; or
5. The Dependent child ceases to be a Dependent eligible for coverage under this behavioral health plan.

Under COBRA, the Insured Person or enrolled Dependent has the responsibility to inform the Employer (or, if applicable, its COBRA administrator) of a divorce, legal separation or a child losing Dependent status under the behavioral health plan within 60 days of the date of the event. The Employer has the responsibility to notify its COBRA administrator of the Insured Person's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, Spouses and dependent children if the Employer commences a bankruptcy proceeding and these individuals lose coverage.

When the COBRA administrator is notified that one of these events has happened, the COBRA administrator will in turn notify the Covered Person of the right to choose continuation coverage. Under the law, the Covered Person has at least 60 days from the date coverage would be lost because of one of the events described above to inform the COBRA administrator that continuation coverage is wanted.

If the Covered Person does not choose continuation coverage on a timely basis, the group behavioral health insurance coverage under this behavioral health plan will end.

If the Covered Person chooses continuation coverage, the Employer is required to give coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated Employees or Dependents. COBRA permits the Covered Person to maintain continuation coverage for 36 months, unless group behavioral health coverage was lost because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This initial 18-month period may be extended for affected individuals up to 36 months from termination of employment if other events (such as a death, divorce, legal separation or Medicare entitlement) occur during that initial 18-month period. In addition, the initial 18-month period may be extended up to 29 months if the Covered Person is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage. Please

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contact the Employer or its COBRA administrator for more information regarding the applicable length of COBRA continuation coverage available.

A child who is born to or placed for adoption with the Insured Person during a period of COBRA continuation coverage will be eligible to enroll as a COBRA-qualified beneficiary. These COBRA-qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the Employer or COBRA administrator of the birth or adoption.

However, under COBRA, the continuation coverage may be cut short for any of the following five reasons:

1. The Employer no longer provides group behavioral health coverage to any of its employees;
2. The Premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered after the date he or she elects COBRA continuation coverage under another group behavioral health plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA continuation coverage; or
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Under the law, the Covered Person may have to pay all of the Premium for the continuation coverage. Premiums for COBRA continuation coverage is generally 102% of the applicable behavioral health plan Premium. However, if the Covered Person is on a disability extension, the cost will be 150% of the applicable Premium. The Covered Person is responsible for the timely submission of the COBRA Premium to the Employer or COBRA administrator. The Employer or COBRA administrator is responsible for the timely submission of Premium to the Company. At the end of the 18-month, 29-month or 36-month continuation

coverage period, qualified beneficiaries will be allowed to enroll in a Company or Designated Medical Conversion Carrier's individual conversion behavioral health plan.

If there are any questions about COBRA, please contact the Employer.

California Continuation Coverage After COBRA

In the event your COBRA coverage began on or after January 1, 2003, and you have used all of your COBRA benefits as described above, you may be eligible to continue benefits under California Continuation Coverage at 110% of the Premium charged for similarly situated eligible employees currently working at your former employment. A notice will be provided to you by the Company at the time your COBRA benefits run out, allowing up to 18 more months under California Continuation COBRA. However, your California Continuation COBRA benefits will not exceed a combined total of 36 months from the date COBRA coverage began.

California Continuation Coverage Enrollment and Premium Information After COBRA

You must notify the Company within 60 days from the date your COBRA coverage terminated or will terminate because of your qualifying event if you wish to elect this continuation coverage; or within 60 days from the date you received notice from the Company. The 60-day period will be counted from whichever event occurs last. Your request must be in writing and delivered to the Company by first-class mail, or other reliable means of delivery, including personal delivery, express mail or private courier company. Upon receipt of your written request, an enrollment package to elect coverage will be mailed to you by the Company. You must pay your initial Premiums to the Company within 45 days from the date the Company mails your enrollment package after you notified the Company of your intent to enroll. Your first Premium must equal the full amount billed by the Company. Your failure to submit the correct premium amount billed to you



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within the 45-day period, which includes checks returned to the Company by your financial institution for non-sufficient funds (NSF), will disqualify you from this available coverage and you will not be allowed to enroll.

Note: In the event you had a prior qualifying event and you became entitled to enroll on COBRA coverage prior to January 1, 2003, you are not eligible for an extension of these benefits under California Continuation COBRA even if you enroll on or after January 1, 2003. Your qualifying event occurs on the first day in which you were initially no longer eligible for your group behavioral health plan coverage from your former Employer, regardless of who your prior insurance carrier may have been at that time.

Termination of Continuation Coverage After COBRA

Your coverage under California Continuation Coverage will terminate when:

1. You have received 36 months of continuation coverage after your qualifying event date; or
2. The end of the period for which Premium payments were made, if you cease or fail to make timely Premiums; or
3. Your former Employer or any successor Employer ceases to provide any group benefit plan to his or her employees; or
4. You no longer meet eligibility for the Company's coverage; or
5. The contract for Behavioral Health Services between you Employer and the Company is terminated; or
6. You become entitle to Medicare. Note: If you were eligible for the 29-month extension as a result of disability and you are later determined by the Social Security Administration to no longer be disabled, you benefits will terminate 36 months after your qualifying event, but only if you send the Social Security Administration notice to your former Employer or COBRA Administration within 30 days of the determination; or

7. If you were covered under a prior carrier and your former Employer replaces your prior coverage with the Company's coverage, you may continue the remaining balance of your unused coverage with the Company, but only if you enroll with and pay Premiums to the Company within 30 days of receiving notice of your termination from the prior behavioral health plan.

If the contract between your former Employer and the Company terminates prior to the date your continuation coverage would terminate under California Continuation COBRA, you may elect continuation coverage under your former Employer's new benefit plan for the remainder of the time period you would have been covered under the prior group benefit plan.

Uniform Service Employment and Reemployment Rights Act (USERRA) Continuation of Benefits under USERRA.

Continuation coverage under this health plan may be available to Insured Persons through the Group Policyholder under the Uniform Service Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). The continuation coverage is equal to, and subject to the same limitations as the benefits provided to other Insured Persons regularly enrolled in this health plan. These benefits may be available to an Insured Person if the Insured Person is absent from employment by reason of service in the United States uniformed services, up to the maximum of 18 month period if Insured Person meets the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended. The Group Policyholder will provide written notice to the Insured Person for USERRA continuation coverage.

The health plan Premium for USERRA continuation of benefits is the same as the health plan Premium for other Insured Persons enrolled through the Group Policyholder plus a 2% additional surcharge or admin-

Section Three

Out-of-Network Covered Person Eligibility



istrative fee, not to exceed 102% of the Group Policyholder's active group Premium. Group Policyholder is responsible for billing and collecting health plan Premiums from Covered/Insured Person and will forward their health plan Premiums to the Company along with the Group Policyholder's Health Plan Premiums due under this Policy.

Additionally, the Group Policyholder is responsible to maintain accurate records regarding USERRA continuation Insured Person health plan Premium, qualifying events, terminating events and any other information that may be necessary for the Company to administer this continuation benefit.

Exception to Effective Date

If an Insured Person's coverage terminates due to an approved leave of absence or military leave, the Company will waive any Waiting Period upon the Insured Person's return; provided:

- a. the Insured Person returns within six months after the leave of absence or military service begins; and
- b. the Insured Person applies or is enrolled within 31 days after returning from the leave of absence or military service.



Overseeing Your Out-of-Network Behavioral Health Services

- *What to Do if the Covered Person Has a Problem or Grievance*
- *Appealing a Behavioral Health Care Decision*
- *Quality of Care Review*
- *The Appeals Process*
- *Independent Medical Review*
- *Statement of ERISA Rights*

This section explains what to do if you have a problem or grievance about your Out of Network Behavioral Health Services; how to appeal a decision of your Out of Network Behavioral Services and how the Company evaluates new behavioral health care technologies and your rights under ERISA.

What to Do if a Covered Person Has a Problem or Grievance

A Covered Person and the Company may not always agree that a Claim had been reviewed properly. When this happens, the Covered Person's first step should be to call the Company's Customer Service Department. The Company's Customer Service Department coordinator will assist the Covered Person and attempt to find a solution to the Covered Person's problem or grievance.

If the Covered Person feels that his/her problem or grievance requires additional action, the Covered Person may also request a formal Appeal. To learn more about this, read the following section: "Appealing a Behavioral Health Care Decision."

Appealing a Behavioral Health Benefit Decision

The Company's appeals and quality of care review pro-

cedures are designed to deliver a timely response and resolution to a Covered Person's problem or grievance. This is done through a process that includes a thorough and appropriate investigation, as well as an evaluation of the problem or grievance. The Covered Person may submit a formal appeal within 1 year of the receipt of an initial determination through our Appeals Department. To initiate an appeal or quality of care review, call the Company's Customer Service Department or write the Appeals Department at the address below to receive an appeals or quality of care packet:

PacifiCare Life and Health Insurance Company
Appeals Department
Post Office Box 55307
Sherman Oaks, CA 91413-0307

A Covered Person, or a representative appointed by a Covered Person including an Attorney, may submit written comments, documents, records and any other information relating to your appeal regardless of whether this information was submitted or considered in the initial determination. You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal. The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

The Quality of Care Review Process

All quality of care complaints requiring clinical review are reviewed by the Company. Complaints affecting your current condition are reviewed immediately. The Company conducts this review by investigating the complaint and consulting with your treating Providers. We also review medical records as necessary, and you may need to sign an authorization to release your medical records.

We will notify you in writing regarding your quality of care review within 30 days of receipt of your complaint. The results of the quality of care review are confidential and protected from legal discovery in

Section Four

Overseeing Your Out-of-Network Behavioral Health Services



accordance with State law.

If a Covered Person has asserted a Claim for benefits or reimbursement as part of a quality of care complaint the Claims for benefits or reimbursement will be reviewed through the Appeals Process described below.

The Appeals Process

The Company will review your appeal within a reasonable period of time appropriate to the circumstances and make a determination not later than 30 days of the Company's receipt of the appeal. For appeals involving the denial or modification of a Claim, the Company's written response will describe the criteria or guidelines used for its decision. For determinations denying or modifying a Claim based on a finding that the services are not Covered Services, the response will specify the provisions in the *Certificate* that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of this *Certificate* captioned "The Quality Review Process."

Binding Arbitration

Any and all disputes of any kind whatsoever, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the behavioral health plan were unnecessary or unauthorized or were improperly, negligent, or incompetently rendered), except for claims subject to ERISA, between the Covered Person (including any heirs or assigns) and the Company, or any of its parents, subsidiaries or affiliates (collectively, "PacifiCare"), shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. The Covered Person and PacifiCare are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single arbitrator in accordance

with the Comprehensive Rules of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date of demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

Arbitration hearings shall be held in the county in which the Covered Person lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by federal and California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, PacifiCare may assume all or part of the Covered Person's share of the fees and expenses of JAMS and the arbitrator, provided the Covered Person submits a hardship application to JAMS. The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration.

BY ENROLLING WITH THE COMPANY BOTH THE COVERED PERSON (INCLUDING ANY HEIRS OR ASSIGNS) AND THE COMPANY AGREE TO WAIVE THE CONSTITUTIONAL



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Overseeing Your Out-of-Network Behavioral Health Services

RIGHT TO A JURY TRIAL AND INSTEAD VOLUNTARILY AGREE TO THE USE OF BINDING ARBITRATION AS DESCRIBED IN THIS CERTIFICATE OF COVERAGE.

Assessment of New Technologies

The Company regularly reviews new procedures, devices and drugs to determine whether or not they are safe and effective. The Technology Assessment and Guideline Committee, which consists of the Company's Medical Directors, Providers, and specialists, conducts careful reviews of case studies, clinical literature, and opinions of review organizations, such as ECRI (formerly the Emergency Care Research Institute), the behavioral health Technology Assessment Information Service, the HAYES New Technology Summaries, the Agency for Behavioral Health Care Policy and Research, Medicare, and Federal Drug Administration decisions.

Statement of ERISA Rights

The following is a general description of the Claims procedures applicable to Employers subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Insured Person should contact their Employer's benefit administrator to determine whether the Employer is subject to ERISA.

- 1) A description of the Company's Claims procedures, including the process for obtaining Pre-Authorization of a Covered Service, is set forth in the *Certificate*.
- 2) The Company processes requests from Covered Persons (or their authorized representatives) for Covered Services pursuant to the following timeframes:
 - a) Non-Urgent Requests. Covered Persons will be notified of decisions to authorize, modify, or deny requests for Covered Services within a reasonable period of time appropriate to the medical condition of the Covered Person but not later than 15 days from the receipt of the

request. The Company may extend the initial timeframe for up to 15 days due to circumstances beyond its control. However, if the extension is necessary due to the Covered Person's failure to submit the information necessary for the Company to make a decision regarding the request, the Covered Person will be notified of the extension, informed of the specific information necessary to make a decision, and provided at least 45 days to provide the specified information. In addition, the time period for making the determination is suspended from the date on which extension notification is sent to the Covered Person until the date on which the Covered Person responds with the specified information.

- b) Urgent Requests. A request for Covered Services will be treated as an "urgent request" if making a determination pursuant to the timeframes in Section (a) above (i) could seriously jeopardize the life or health of the Covered Person, or (ii) if in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. In the event of an urgent request, the Company will notify the Covered Person of its determination as soon as possible, taking into account the Covered Person's medical condition, but not later than 72 hours after receipt of the urgent request. In the event the Company does not have the information necessary to make a decision regarding the request, the Company will notify the Covered Person as soon as reasonably possible, but not later than 24 hours after receipt of the request and will inform the Covered Person of the specific information necessary for the Company to make a determination regarding the request, and the timeframe for the Covered Person to provide the specified information.

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Overseeing Your Out-of-Network Behavioral Health Services



- c) **Concurrent Care Requests.** If the Covered Person requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an “urgent request” as defined in Section (b) above, the Company will approve, modify or deny the request as soon as possible, taking into account the Covered Person’s medical condition, and will notify the Covered Person of the decision within 24 hours of the request, provided the Covered Person made the request to the Company at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an “urgent request” as defined in Section (b) above, the Company will treat the request as a new request for a Covered Service under the health plan and will follow the time frame for non-urgent requests as discussed in Section (a) above.

Covered Persons have up to 180 days following receipt of an adverse determination within which to appeal the determination. Covered Persons are entitled to a full and fair appeals process. Covered Persons may submit written comments, documents, records and information in support of their appeal. The Company will notify the s Covered Person of its decision regarding the appeal no later than:

- One business day for an expedited medical review
- 30 days for the denial of an initial request for a service not yet provided
- 60 days for the denial of a Claim for services already provided but not yet paid for.



Out-of-Network Definitions

The Company is dedicated to making its services easily accessible and understandable. To help you understand the precise meaning of many terms used to explain your benefits, we have provided the following definitions. The following definitions are for both Chemical Dependency and Mental Behavioral health benefits that are provided on an Out-of-Network basis. These definitions apply to the capitalized terms used in your *Certificate of Coverage*, as well as the *Schedule of Benefits*.

Actively at Work or Active Work: A Person's full-time performance of all customary duties of the Person's occupation at the Employer's place of business, or at another business location to which the Employer requires the Person to travel.

Administrator: An appropriately licensed organization with whom the Company has contracted to perform administration services. Applicable Administrators are identified under the "Administrators" section of this *Certificate*.

Appeals Procedure: the procedure for reviewing Covered Person complaints.

Application: means all forms required to be completed by the Policyholder, Insured Person or Dependent.

Behavioral Health Services: Services rendered or made available to a Covered Person for treatment of Chemical Dependency or Mental Disorders.

Behavioral Health Treatment Program: A structured treatment program aimed at the treatment and alleviation of Chemical Dependency or Mental Disorders.

Calendar Year: Means that period of time commencing at 12:00 a.m., on January 1 and ending at 11:59 p.m. December 31, of the same year.

Charges Incurred: Charges are considered to be incurred on the date the service or supply is rendered or obtained.

Chemical Dependency: An addictive relationship of a Covered Person to any drug, Alcohol, or chemical substance that can be documented according to the criteria in the Diagnostic and Statistics Manual IV-TR. Chemical Dependency does not include addiction to or dependency on tobacco in any form; or food substances in any form.

Chemical Dependency Treatment Program: A structured medical and behavioral treatment program aimed at the alleviation of Chemical Dependency.

Claims: means notification in a form acceptable to the Company that a service or supplies have been rendered or furnished to a Covered Person. This notification must set forth in full details of such service or supplies as required by the Company.

Claim Determination Period: A Calendar Year or that part of the Calendar Year during which a person is covered by this Plan.

Clinician: A person licensed as a psychiatrist, psychologist, clinical social worker, marriage family child counselor, nurse or other licensed behavioral health care professional with appropriate training and experience in Behavioral Health Services, to perform case management services which include assessing Chemical Dependency and Psychiatric Disorders, referring to appropriate Facilities and/or Practitioners, monitoring and reviewing care received by Insured, participating in provider relations and coordinating behavioral health care benefits for Insured.

COBRA: means those section of the Consolidated Omnibus Budget Reconciliation Act of 1985 which regulates the conditions and manner in which an employer must offer continuation of group behavioral health insurance to Covered Persons whose coverage would otherwise terminate under the terms of this Policy.

Coinsurance: means that portion of the Covered Expense, which is not payable as a benefit due to the Percentage Payable being less than 100%. Coinsurance does not include any Deductibles or Copayments. Coinsurance does not include any amounts payable by the Covered Person which are not considered as

Section Five

Out-of-Network Definitions



Covered Expense under the Policy.

Company: PacifiCare Life and Health Insurance Company

Copayment: Portion of Covered Expense which is the responsibility of the Covered Person and which are shown as Copayments on the *Schedule of Benefits*.

Covered Expense: Expense that:

1. is incurred for a Covered Service provided to a Covered Person while that person is covered under the Policy;
2. does not exceed the smallest of any Policy Maximum that may apply to the expense;
3. for a Practitioner, does not exceed the Usual and Customary Charge; and
4. for a Facility, does not exceed the applicable fee schedule and;

Covered Expense is incurred on the date the Covered Person receives the service or supply for which the charge is made.

Covered Person: means the Insured and/or the Insured's Dependent(s) who are covered under this Policy.

Covered Services: a service or supply that is included in Section One: Behavioral Health Benefits section of the *Certificate* and is prescribed by a license Provider.

Custodial Care: Personal services required to assist the Covered Person in meeting the requirements of daily living. Custodial Care is not covered under this behavioral health Plan. Such services include, without limitation, assistance in walking, getting in or out of bed, bathing, dressing, feeding, or using the lavatory, preparation of special diets and supervision of medication schedules. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

Day Treatment Center: means a Facility which provides Behavioral Health Treatment Program on a full or part-day basis pursuant to written treatment plan approved and monitored by a Provider, and which

Facility is also licensed, certified or approved as such by the appropriate state agency.

Deductible: means the amount of Covered Expense a Covered Person is responsible to pay before benefits become payable under this Plan.

Dependent or Eligible Dependent: A member of an Insured Person's family (Spouse, Domestic Partner, an unmarried child of the Insurance Person, the Insured Person's Spouse or the Insured Person's Domestic Partner through the Limiting Age), who is financially dependent upon the Insured Person, and an unmarried child of the Insured Person, the Insured Person's Spouse or the Insured Person's Domestic Partner, of any age, who is medically certified as disabled and dependent upon the Insured Person, who is enrolled with the Company after meeting all the of the eligibility requirements of the Insured Person's Employer and the Company, and for whom applicable health plan premiums have been received by the Company.

Diagnostic and Statistical Manual IV-TR

(DSM IV-TR): The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, which is published by the American Psychiatric Association and which lists the criteria for diagnosis of Chemical Dependency and Mental Disorders.

Domestic Partner: is a person who meets the eligibility requirements, as defined by the Employer, and the following:

- (i) Is eighteen (18) years of age or older;
- (ii) Is mentally competent to consent to contract;
- (iii) Resides with the Subscriber and intends to do so indefinitely;
- (iv) Is jointly responsible with the Subscriber for their common welfare and financial obligations;
- (v) Is unmarried or not a member of another domestic partnership; and
- (vi) Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

Effective Date: means (i) with respect to this Policy,



Section Five Out-of-Network Definitions

the date stated as the Effective Date on the face page of the Policy, and (ii) with respect to any Covered Person, the date such Covered Person is first covered under this Policy.

Emergency or Emergency Services: A behavioral health condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate Behavioral Health Services to result in any of the following:

1. Immediate harm to self or others;
2. Placing the Covered Person's behavioral health in serious jeopardy;
3. Serious impairment to bodily functions; or
4. Serious dysfunction of any bodily organ or part

Employer: means the Group Policyholder and/or any Employer approved by the Company for participation in the coverage provided by the Policy.

Employee or Insured Person: A person who is Actively Employed and who continues to satisfy the eligibility criteria established by your Employer.

Facility: A Facility which is duly licensed by the state in which it operates to provide inpatient, residential, day treatment, partial hospitalization or outpatient care for the diagnosis and/or treatment of Chemical Dependency and/or Mental Disorders.

Family: The Insured Person and his or her Dependent(s) who are insured under the Policy.

Full-time Employee: means an employee of the Employer a) whose employment with the Employer is the employee's principal occupation; and b) who is regularly scheduled to work at such occupation at least the minimum number of hours shown in the Policy Information Page of the Policy.

Group Policyholder: The person, partnership, corporation or trust as shown on the Policy Information Page of the Policy.

Inpatient Treatment Center: An acute care Participating Facility which provides Behavioral Health Services, under 24 hour nursing and medical super-

vision in an acute, inpatient setting, pursuant to a written Behavioral Health Treatment Plan approved and monitored by a PBHC Participating Practitioner and is licensed, certified, or approved as such by the appropriate state agency.

Insured Month: period of time as follows:

1. beginning at 12:00 a.m. Standard Time at the Group Policyholder's principal location on the first day of any calendar month; and
2. ending at 11:59 p.m. on the last day of the same calendar month

Insured Person: The person enrolled in the behavioral health plan for whom the appropriate Premiums have been received by the Company and whose employment or other status, except for Family dependency, is the basis for enrollment eligibility.

Limiting Age: The age established by the Company when a Family member is not longer eligible to be enrolled under the Insured's coverage.

Medical Detoxification: The medical treatment of withdrawal from alcohol, drug or other substance addiction. These services are covered under your medical plan.

Medicare: The Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under the Title XVIII of the Social Security Act, as amended.

Medicare Eligible: Those Covered Persons who meet eligibility requirements under Title XVIII of the Social Security Act, as amended.

Mental Disorder: A mental or nervous disorder diagnosed by a licensed Practitioner according to the criteria in the DSM IV-TR and limited to severe impairment of a Covered Person's mental, emotional or behavioral functioning on a daily basis.

Open Enrollment Period: A period of time as specified in the Application of the Employer and determined periodically by the Company and the Employer, during which all Insured Persons and their Dependents may enroll for coverage under this plan.

Section Five

Out-of-Network Definitions



Out-of-Network Coverage: A supplemental indemnity insurance plan underwritten by the Company as part of the PBHC Plan. The Out-of-Network Coverage provides limited coverage for certain Behavioral Health Services, as described in the *Schedule of Benefits*, when provided by any licensed practitioner.

Outpatient: Behavioral Health Treatment from a license Provider in a Facility other than on an Inpatient basis.

Outpatient Treatment Center: A Facility which provides a Behavioral Health Treatment Program in an outpatient setting, and which Facility is also licensed, certified or approved as such by the appropriate state agency.

Policy: The Group Behavioral Health Insurance Policy issued by the Company to the Group Policyholder.

Policy Anniversary: The annual date stated as the “Policy Anniversary” on the Policy Information Page of the Policy.

Policy Effective Date: The date stated as the “Policy Effective Date” on the Policy Information Page of the Policy.

Policyholder: means the Employer which has executed an Application for this Policy and to which this Policy has been issued.

Policy Maximum: The combined maximum amount of Behavioral Health Services provided to Covered Person. The Policy has both annual and lifetime maximums as set forth in the *Schedule of Benefits*.

Practitioner: A psychiatrist, psychologist, registered nurse, a licensed clinical social worker or a marriage family child counselor who is duly licensed or certified under the appropriate state laws and who provides Behavioral Health Services.

Premiums: The payments made to the Company by the Group Policyholder on behalf of an Covered Persons for the covered period under the Policy.

Provider: A person, group, Facility or other entity that is licensed or otherwise qualified to deliver any of the Behavioral Health Services described in this *Certificate*

and *Schedule of Benefits*.

Quality Management Manager: responsible for directing Insured complaints to the appropriate review process and for conducting the initial review for quality of care complaints.

Quality Management Program: the procedures and standards established and administered by the UR Administrator to ensure that Behavioral Health Services rendered by a Participating Provider comply with the standards of professional care acceptable to the community in which the care is rendered.

Residential Treatment Center: A residential facility that provides services in connection with the diagnosis and treatment of behavioral health conditions and which is licensed, certified, or approved as such by the appropriate state agency.

Schedule of Benefits: An important part of this *Certificate* that provides additional benefit information including Coinsurance, Copayment, Deductible and limitation information.

Serious Emotional Disturbances of a Child (SED): A Serious Emotional Disturbance of a Child is defined as a condition a child who:

- 1) Has one or more Mental Disorders as defined by the Diagnostic and Statistical Manual (DSM-IV-TR), other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child’s age according to expected developmental norms; and
- 2) Is under the age of eighteen (18) years old.
- 3) Furthermore, the child must meet one or more of the following criteria:
 - a. As a result of the Mental Disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
 - (i) the child is at risk of removal from home or has already been removed from the home;



Section Five Out-of-Network Definitions

- (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
- b. The child displays one of the following:
 - psychotic features, risk of suicide or risk of violence due to a Mental Disorder; or
- c. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

Spouse: The Insured Person's legally recognized husband or wife under the laws of the state in which the Group Policy is delivered.

Severe Mental Illness (SMI): Severe Mental Illness includes the diagnosis and treatment of the following conditions:

- Anorexia Nervosa
- Bipolar Disorder
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism.
- Schizoaffective Disorder
- Schizophrenia

Total Disability or Totally Disabled: means when an Insured Person, because of Mental Disorders or Chemical Dependency is completely prevented from performing the material and substantial duties of any occupation for which her or she is qualified by education, training or experience. A Dependent who is covered under the terms and conditions of this Policy, as a result of Mental Disorder or Chemical Dependency, is unable to perform the activities and

duties of an individual of like age and sex.

Usual and Customary: means the lesser of:

1. a Provider's usual charge for furnishing treatment, service or supply; or
2. the charge the Company determines to be the general rate charged by others who render or furnish such treatment, services or supplies to person who reside in the same area and whose condition is comparable in nature and severity.

Visit: An outpatient session with a Practitioner conducted on an individual or group basis.

Waiting Period: the period of time an employee must be continuously employed by the Employer before becoming eligible for coverage under the Policy.

NOTE: THIS *CERTIFICATE* CONSTITUTES ONLY A SUMMARY OF THE COMPANY BEHAVIORAL HEALTH PLAN. THE POLICY BETWEEN THE COMPANY AND THE GROUP POLICYHOLDER MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A COPY OF THE POLICY WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT PACIFICARE LIFE AND HEALTH INSURANCE COMPANY AND THE EMPLOYER'S PERSONNEL OFFICE.

Notes





Notes

**3120 Lake Center Drive
Santa Ana, CA 92704-6917**

Customer Service:

800-999-9585

888-877-5378 (TDHI)

24 hours a day, seven days a week

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