

About This Booklet

Please read this Combined Evidence of Coverage & Disclosure Form (“Evidence of Coverage”) carefully to understand your MHN benefits. This Evidence of Coverage discloses the terms and conditions of coverage and can help you understand your rights and responsibilities as a Member. If you have behavioral healthcare needs, you should carefully read those sections that apply to you. Certain terms are capitalized throughout this Evidence of Coverage - to help you understand these terms, the meaning and limitations of these terms are explained in the “Definitions” section of this booklet.

You have the right to view the Evidence of Coverage prior to enrollment. This Evidence of Coverage is only a summary of the health plan contract (the “Agreement”) between MHN and your Employer or Group. Please review the Agreement to determine the governing contractual provisions. A copy of the Agreement will be furnished upon request. To receive a copy of the Agreement or if you have questions or concerns after reading this Evidence of Coverage and need additional information about your benefits, please contact MHN at 1-800-777-9355.

This Evidence of Coverage, the Agreement and Benefits of this Plan are subject to change without your consent, according to the provisions of the Agreement. If this Evidence of Coverage has been issued to an existing MHN Group, it replaces the former Evidence of Coverage, effective upon the date in the Agreement. Please refer to the most recent Evidence of Coverage, as Benefits may have changed from those stated in the prior Evidence of Coverage.

By enrolling in, or accepting services under, this Plan, Members agree to abide by all terms, conditions and provisions stated in the Agreement and this Evidence of Coverage. Members must notify MHN of any change in residence and any circumstances that may affect entitlement to coverage or eligibility under this Plan. Members must also immediately disclose to MHN if they have filed a Workers’ Compensation claim, or were injured by a third party.

As a condition of enrollment and to receive benefits under this Plan – MHN, its agents, independent contractors and Participating Practitioners shall be entitled to release to, or obtain from, any person, organization or government agency, any information and records, including patient records of Members, which MHN requires or is obligated to provide pursuant to legal process, or federal, state or local law. Each Member expressly consents to, authorizes and directs Participating Providers, or others who are giving treatment or advice, to make available to MHN such medical and mental health reports, records and other information, or copies thereof, as MHN may request for the purposes of administering this Plan.

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Member Rights & Responsibilities

As a Member, you have the right to:

- Receive information regarding MHN services and clinical guidelines.
- Call MHN for assistance 24 hours a day, 365 days a year.
- Call “911” in an Emergency.
- Ask questions about and see documentation of your Practitioner’s credentials and experience.
- Receive prompt, competent and courteous treatment from all MHN staff and Practitioners.
- Discuss appropriate or medically necessary treatment options, regardless of cost or benefit coverage, and obtain a clear explanation of MHN’s criteria for determining medical necessity.
- Confidentiality of your medical records to the extent protected by state and federal law.
- Obtain an explanation regarding legally required exceptions to confidentiality.
- Receive a clear explanation from your Practitioner about the recommended Treatment Plan and length of treatment.
- Participate in decision-making regarding your treatment.
- Refuse or terminate treatment at any time.
- Be treated with respect and recognition of your dignity and need for privacy.
- Receive an explanation from your Practitioner of any consequences that may result from refusing treatment.
- Obtain a clear explanation of MHN’s reasons for determining that care is not Medically Necessary.
- Appeal a denial.
- File complaints with MHN, or the California Department of Managed Health Care or applicable State Department of Insurance, if you experience problems with MHN or your Practitioner.
- Suggest ways to improve MHN Member Rights & Responsibilities policies and procedures.
- Receive a complete explanation of your fees and charges.

As a Member, it is your responsibility to:

- Consent to providing information (from you or your provider) needed by MHN and/or your provider, to provide proper treatment.
- Actively participate in developing treatment goals and strategies for achieving those goals.
- Follow the Treatment Plans you have agreed upon with your Practitioner.
- Cancel appointments within the guidelines described by MHN or your Practitioner.
- Read your Evidence of Coverage or other material outlining your behavioral health benefits.
- Ask questions to ensure your understanding of Covered Services, limitations and any Authorization procedures, and comply with the rules and conditions as stated.
- Pay any Copayments at the time of service.
- Demonstrate courtesy and respect to your Practitioner, the Practitioner’s staff and MHN’s employees, and expect similar treatment in return.

Program Overview

To help you with emotional, stress-related or substance abuse issues, **Long Beach Community College District** has made available to you and your eligible family members high quality, affordable Behavioral Healthcare Services. These services are provided through MHN's Employee Assistance Program ("EAP") and Behavioral Healthcare Services.

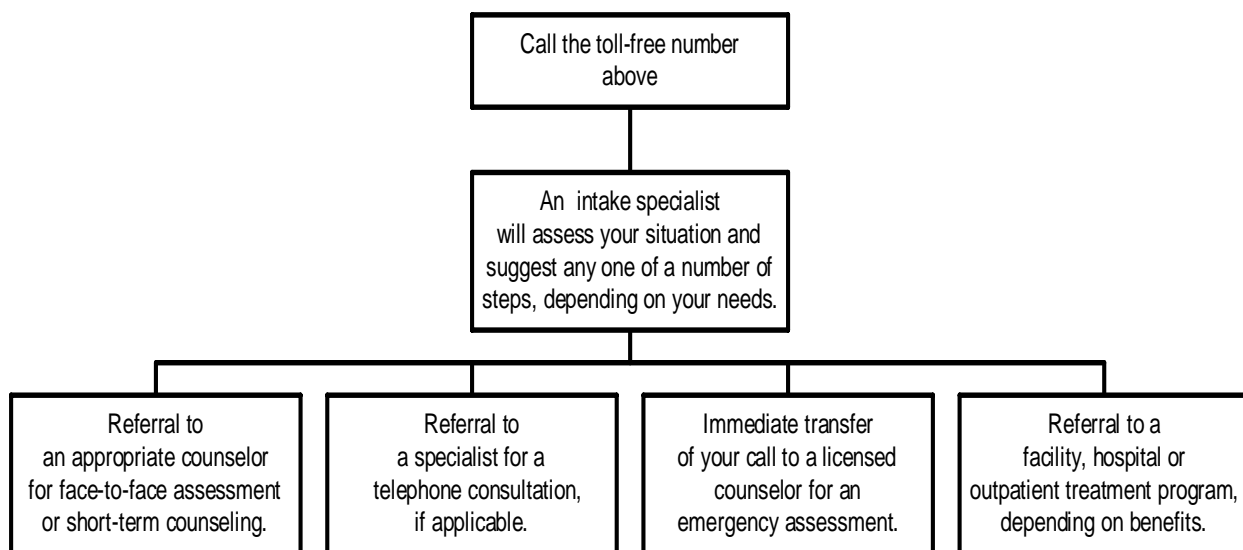
EAP provides counseling for personal or family-related problems or concerns. EAP is also the "gateway" to Behavioral Healthcare Services, if you require treatment beyond EAP Sessions covered under this Plan.

If you use MHN's services, your treatment will be afforded the confidentiality protected by state and federal law. Exceptions to confidentiality include, but are not limited to, mandatory reporting of child and elder abuse, subpoena or court order and certain disclosures made by persons dangerous to themselves or others. A statement describing MHN's policies and procedures for preserving the confidentiality of medical records is available and will be furnished upon request. You may also view the policies at the back of this booklet and on MHN's web site at www.MHN.com.

You acknowledge that health care providers may disclose health information about you or your dependents, including information regarding substance abuse or mental/emotional conditions, to MHN. MHN uses and discloses this information for purposes of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement and disease or case management programs.

You can call MHN toll-free, 24 hours a day, 365 days a year at 1-800-777-9355.

How the Program Works:



Important Information About Preauthorization

To access your Behavioral Healthcare Services, you must first obtain Authorization of coverage and a referral from MHN to a Participating Practitioner – unless specifically stated otherwise in this Evidence of Coverage. Detailed benefit information is located on the Benefit Chart listed in the Appendix section of this booklet.

Except in an Emergency, services and supplies provided without Preauthorization will not be covered by MHN – even if those services or supplies would have been covered had the Member requested Preauthorization.

Preauthorization of coverage by MHN is conditioned upon the Member’s eligibility for coverage at the time the Covered Services are received. If the Member was not eligible for coverage after Preauthorization was given, MHN will deny coverage accordingly.

Employee Assistance Program (EAP)

EAP provides short-term counseling and consultation services. Counselors will identify, discuss, and develop a plan of action to help resolve your problem. For longer-term care, your Participating Practitioner will work with MHN to facilitate continued treatment based on your coverage.

You can access EAP by calling MHN 24 hours a day, 365 days a year at 1-800-777-9355. EAP Sessions are available either through telephone consultations or in-person appointments, depending on the type of service and applicable benefit plan. Referral and Preauthorization are always required for EAP services. MHN only provides an EAP referral to one of its Participating Practitioners.

EAP provides 50-minute Sessions with an MHN Participating Practitioner for a wide range of personal issues. Call MHN any time when you need help for:

- Stress
- Anxiety
- Depression
- Relationship problems
- Family issues
- Anger management
- Substance abuse
- Life transitions
- Bereavement

Please consult the Benefit Chart listed in the back section of this booklet for detailed benefit information.

Behavioral Healthcare Services

MHN arranges for the provision of Inpatient and Outpatient Behavioral Healthcare Services. MHN reviews your mental health and/or substance abuse needs with your Participating Provider to confirm the requested care is Medically Necessary. If MHN determines that the requested care is Medically Necessary and covered under this Plan, coverage is authorized according to the Benefits, terms and conditions set forth in this Evidence of Coverage.

Under this Plan, MHN only authorizes and pays for Medically Necessary treatment, as defined in the “Definitions” section of this booklet. For a detailed explanation of your Employer’s or Group’s specific Behavioral Healthcare Services, please refer to the Benefit Chart in the back section of this booklet.

How Do I Obtain Behavioral Healthcare Services?

Emergency Care

If you are experiencing severe symptoms and are impaired in your functioning to the extent that you present an immediate danger to yourself or others or you are in crisis and need immediate assistance, call the **911** emergency response system or go to the nearest emergency room. If you are in crisis and need immediate assistance, MHN’s licensed counselors also are available 24 hours a day, 365 days a year for immediate telephone intervention and consultation.

- ✓ In an Emergency, Preauthorization for treatment is **not** required. However, you, your Participating Provider, or your family member should call MHN as soon as possible after an Emergency Admission for Authorization of care rendered following Emergency Services and Care.
- ✓ MHN will review your case (i.e., eligibility, appropriateness and quality of treatment). If approved, a treatment Authorization will be communicated to your Participating Provider.
- ✓ If you are out of California and require Emergency care, please call MHN any time of the day or night for a referral to one of our nationwide Participating Providers. If there are no Participating Providers within a 30-mile radius of your area, MHN will refer you to a non-Participating Provider. In the event that MHN cannot find you a referral, you should go to the nearest provider.
- ✓ If you require Emergency care when a Participating Provider is not available, all Covered Services will be covered only until such time as it is medically appropriate for you to transfer to a Participating Provider. MHN may limit coverage under this Plan to services and supplies rendered by Participating Providers if MHN determines that transfer to a Participating Provider is medically appropriate. Your consent and cooperation with this transfer is a condition of coverage under this Plan. Refusal of transfer may result in denial of coverage from the date that MHN determines it is medically appropriate for the Member to transfer to a Participating Provider.

Non-Emergency Care

- ✓ Call MHN at 1-800-777-9355 for a referral to a Participating Provider and to request Authorization of treatment.
- ✓ If you think you require an Inpatient, residential or structured treatment program, you must obtain Preauthorization from MHN. You must provide all necessary information concerning your problem before you begin treatment.
- ✓ MHN will evaluate your problem and refer you to a Participating Practitioner or Participating Facility Provider. MHN will contact the Participating Provider to confirm the authorized treatment.

- ✓ MHN will continue to review your treatment with your Participating Provider to determine Medical Necessity and the appropriate level of care for your problem. MHN must authorize all Behavioral Healthcare Services, including transfers to different levels of care and any additional services. Please refer to the “Utilization Review” section of this booklet for more information.

Utilization Review

This Plan includes prior, concurrent and retrospective reviews of certain proposed treatments to determine whether the proposed treatment is Medically Necessary and if the services are covered under this Plan. An example of *concurrent review* is MHN’s review of whether current use of an Inpatient facility is the appropriate treatment setting for the patient’s symptoms. An example of *retrospective review* is MHN’s review of whether past use of a hospital was appropriate for the patient’s symptoms.

The final judgment of the reviewer or professional review organization is not a substitute for the independent judgment of the treating Practitioner, Hospital or Facility as to the course of treatment. Utilization review decisions which are not consistent with a treating Practitioner, Hospital or Facility’s determination do not preclude treatment or hospitalization – but do determine MHN’s coverage for such treatment or hospitalization under this Plan.

Claiming Benefits

All actions described in this section to be taken by a claimant (Member), likewise may be taken by a representative of the claimant duly authorized by him or her to act on his or her behalf in such matters (an “Authorized Representative”). MHN may require such evidence it deems reasonably necessary or advisable to verify the authority of any such representative to act. You do not need to complete claims forms for Behavioral Healthcare Services obtained by Participating Providers. Participating Providers will file the claim for you and will be paid directly by MHN.

Types of Claims or Requests for Authorization

The requirements for processing claims or requests for Authorization depend on the type of claim or request submitted. A claim or request is defined as urgent, pre-service, post-service or concurrent.

Urgent Care Claims: An Urgent Care Claim is any claim for medical care or treatment with respect to which the application of standard processes for making care decisions:

- Could seriously jeopardize your life, health or ability to regain maximum function; or
- Would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Determinations regarding the severity of pain must be made by a physician with knowledge of your medical condition.

If a physician with knowledge of your medical condition determines that your claim is an Urgent Care Claim, MHN will treat it as such. A health care professional with knowledge of your medical condition shall be permitted to act as your Authorized Representative for purposes of filing and appealing an Urgent Care Claim.

Pre-Service Claims: A Pre-Service Claim is a request for authorization of medical care or treatment that you have not yet received, which is conditioned in whole or in part on MHN's approval of coverage in advance of obtaining the medical care.

Post-Service Claims: A Post-Service Claim is a request for payment or reimbursement of costs for medical care that has already been provided and which is not an Urgent Care Claim or a Pre-Service Claim.

Concurrent Care Claims: A Concurrent Care Claim is a request for authorization of an extension or modification to an approved course of treatment that is already in progress, such as an inpatient hospitalization.

Failure To Follow Procedures In Submitting A Claim

If you fail to follow the proper procedures when filing a Pre-Service Claim or Urgent Care Claim, MHN will notify you regarding the proper procedures to be followed to complete the claim within:

- 5 days of MHN's receipt of a Pre-Service Claim; or
- 24 hours of MHN's receipt of an Urgent Care Claim.

Insufficient Information

If MHN requires additional information in order to make a determination, you will be notified regarding what information is necessary and given a reasonable amount of time to provide MHN with the requested information.

Notice Of Determination

Note: MHN reserves the right to extend the time periods specified below as allowed by law if such extension is necessary due to matters beyond the control of MHN.

Urgent Care Claims: MHN will notify you of its decision (whether or not to pay the claim) as soon as possible, taking into account medical exigencies, but not later than 72 hours after MHN's receipt of your Urgent Care Claim.

If you fail to provide MHN with information sufficient to enable MHN to decide your claim, you will be notified of such failure as soon as possible, but not later than 24 hours after MHN's receipt of the insufficient information. You will then be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. After you provide the specified information, MHN will provide you with its decision on the claim as soon as possible, but in no case later than 48 hours after the earlier of:

- MHN's receipt of the specified information, or
- The end of the period afforded you to provide the specified additional information.

Pre-Service Claims: MHN will notify you of its decision (whether or not to pay the claim) as soon as possible but no later than fifteen (15) days after MHN's receipt of your Pre-Service Claim.

MHN reserves the right to a single extension of this 15-day period of an additional 15 days if MHN determines that the extension is necessary due to matters beyond its control. You will be notified prior to the expiration of the initial 15-day period of the circumstances requiring the extension of the time and date by which MHN expects to render a decision.

If the extension described above is necessary because you failed to submit the information necessary to decide the claim, the notice of extension must describe specifically the required information. You shall be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

Post-Service Claims: MHN will notify you of its decision (whether or not to pay the claim) as soon as possible no later than 30 days after MHN's receipt of your Post-Service Claim. MHN reserves the right to a single extension of this 30-day period for up to an additional 15 days if MHN determines that the extension is necessary due to matters beyond its control. You will be notified prior to the expiration of the initial 30-day period of the circumstances requiring the extension of the time and date by which MHN expects to render a decision.

If the extension is necessary because you failed to submit the information necessary to decide the claim, the notice of extension will describe specifically the required information. You will be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

Concurrent Care Claims: If MHN has approved an ongoing course of treatment to be provided to you over a period of time or a number of treatments, MHN's reduction or termination of the course of treatment (other than by amendment or termination of this Plan) constitutes a denial of

your claim. Any reduction or termination by MHN of the approved course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed is considered an adverse benefit determination. In the event of such a denial, MHN will notify you in sufficient time prior to the reduction or termination in order to allow you to appeal and obtain a determination on appeal before the benefit is reduced or terminated.

If you request that the course of treatment be extended beyond the period of time or number of treatments originally approved and such request is an Urgent Care Claim, the request will be decided as soon as possible, taking into account the medical exigencies. MHN will notify you of its benefit determination (whether or not to pay the claim) not later than 24 hours after its receipt of the claim, provided the request for an extension is made at least 24 hours prior to the expiration of the originally approved period of time or number of treatments.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment and the request to extend is an Urgent Care Claim, the claim will be decided according to the Urgent Care Claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to Pre-Service Claim or Post-Service Claim time frames, whichever applies.

If the Claim or Request Is Denied

If the claim or request is denied, delayed or modified due to determination that the services or treatment were not Medically Necessary or appropriate, either in whole or in part, you will receive a written notice explaining the reasons for the determination including:

- The specific reason or reasons why the claim was denied, delayed or modified.
- Reference to the MHN plan provisions on which the decision is based.
- If more information is needed, a description of any material necessary to process the claim properly and why the materials are needed.
- A description of MHN's appeals process and any time limits applicable to such procedures.
- A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in denying the claim, or a statement that a copy will be provided free of charge upon request.
- If your claim or request was denied based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the MHN plan to the claimant's medical circumstances or a statement that such an explanation will be provided free of charge upon request.
- If your claim or request was an Urgent Care Claim, a description of the expedited review process available to the claimant. This initial determination may be explained orally, followed by a written or electronic notice containing that information within 3 days.

Appealing A Denial Of Medical Benefits

After receiving a denial, to appeal it, you or your Authorized Representative must submit a written request for review by MHN. The request must be made within 180 days and should be accompanied by documents or records in support of the appeal. You may make your appeal request telephonically by calling MHN at (888) 426-0028. As part of the review procedure, you or your Authorized Representative are entitled to:

- Examine and obtain copies, free of charge, of all health plan documents, records and other information that were used in making the determination.
- Submit written comments, documents, records, and other information relating to the claim or request.
- Obtain information identifying the medical or vocational experts whose advice was obtained on behalf of MHN in connection with the denial of the claim or request. (You are entitled to this information even if MHN did not rely on the information in making its determination).
- Have someone act as your representative in the review procedure, if you wish.

In addition, MHN's review of the appeal must be conducted in accordance with the following rules:

- MHN may not defer to the initial denial of the claim or request. Review of the appeal must be conducted by a MHN Medical Director who is neither the individual who initially denied the claim or request, nor a subordinate of such individual.
- If denial of the initial claim or request was based in whole or in part on a medical judgment (including decisions as to whether a drug, treatment, or other item is experimental, investigational, or not Medically Necessary or appropriate), a MHN Medical Director must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional cannot be an individual who was consulted in connection with the initial decision on the claim or request, nor the subordinate of such an individual.
- If you are appealing the denial of an Urgent Care Claim, the request for an expedited appeal may be submitted orally or in writing, and all necessary information may be transmitted between you and MHN by telephone, facsimile or any other available efficient method.

MHN will notify you of the decision on the appeal. Such notice will be provided to you:

- As soon as possible, taking into account the medical exigencies, but not later than 72 hours after MHN's receipt of the appeal of an Urgent Care Claim.
- Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after MHN's receipt of the appeal of a Pre-Service Claim.
- Within a reasonable period of time, but not later than 30 days after MHN's receipt of the appeal of a Post-Service Claim.

If the appeal is denied, a written notice containing the information set forth below will be provided.

- The specific reason or reasons for the denial of the appeal.
- Reference to the specific MHN plan provisions on which the denial is based

- A statement that you are entitled to receive, upon request and free of charge, access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, a copy of that rule, guideline, protocol or criterion, or a statement that a copy will be provided free of charge upon request.
- If the claim or request was denied based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the MHN plan to the claimant's medical circumstances or a statement that such an explanation will be provided free of charge upon request.

MHN Levels of Appeal

A request for an appeal because of a denial of Authorization can be made by Members, Practitioners, Facilities or the Member's Authorized Representative.

If MHN's decision involves a delay, denial or modification of health care services related to an Experimental or Investigational Therapy, MHN's written determination will inform the enrollee of his/her immediate right to submit an application for Independent Medical Review ("IMR") to the Department of Managed Health Care (the "Department") if certain conditions are met. The Member need not first participate in MHN's Appeal Process. Please see the section on "Independent Medical Review" for further information.

MHN Mandatory Internal Review: If the Member has an Urgent Care Claim, the Member or his or her provider or Authorized Representative can request an expedited, telephonic appeal of a denial of Authorization for payment by calling MHN at (888) 426-0028. An appeal via telephone will be arranged and concluded within seventy-two hours with a Peer Reviewer different from the one who issued the initial denial.

Standard Written Appeal: If the Member does not have an Urgent Care Claim, the Member or Provider may submit a Standard Written Appeal. Appeal determinations are made within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of such claim in the case of Pre-Service Claims and 30 days after receipt for Post-Service Claims. A Peer Reviewer different from the one who made the initial denial decision, reviews the request. The appeal request may be made telephonically by calling MHN at (888) 426-0028 or by sending a written request to:

MHN
Appeals Unit
 503 Canal Boulevard
 Pt. Richmond, CA 94804-1807

Independent Medical Review (Voluntary for Members): If the decision constitutes a denial of benefits and the Member has exhausted the MHN Mandatory Internal Review described above, the Member may request a review by the Independent Medical Review ("IMR") organization under contract with the Department. The Member has the right under California law to apply to the Department for IMR if:

1. The Member believes that health care services eligible for coverage and payment under their MHN plan subscriber contract have been improperly denied, modified, or delayed by MHN or one of its Participating Providers because the service is not **Medically Necessary** (see the section below entitled “Medical Necessity”); **OR**
2. MHN’s decision involves a delay, denial or modification of health care services related to a denial of coverage for an **Experimental or Investigational Therapy** (see the section below entitled “Experimental or Investigational Therapy”).

Unless the Member’s situation requires immediate attention, when a decision is based on a determination of Medical Necessity, the Member may request IMR from the Department after participating in MHN’s Appeal Process for 30 days. If the denial of coverage is related to an Experimental or Investigational Therapy the Member may apply immediately to the Department for IMR; there is no requirement to participate in MHN’s Appeal Process for 30 days.

Medical Necessity: You may request an IMR of Disputed Health Care Services from the Department if you believe that health care services eligible for coverage and payment under your MHN plan have been improperly denied, modified, or delayed by MHN or one of its Participating Providers. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under your MHN plan that has been denied, modified, or delayed by MHN or one of its Participating Providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. MHN must provide you with an IMR application form with your grievance disposition letter that denies, modifies, or delays health care services. This disposition letter will state MHN’s position on the Disputed Health Care Service. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR.

Eligibility: Your application for IMR will be reviewed by the Department to confirm that it meets all the eligibility requirements of the law for IMR set out below:

1. (A) Your Participating Provider has recommended a health care service as Medically Necessary, or (B) You have received urgent care or emergency services that a Participating Provider determined to have been Medically Necessary, or (C) In the absence of the Participating Provider recommendation described in (1)(A) above, you have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which you seek IMR;
2. The Disputed Health Care Service has been denied, modified, or delayed by MHN or one of its Participating Providers, based in whole or in part on a decision that the health care service is not Medically Necessary; and
3. You have filed a grievance with MHN and the disputed decision is upheld or the grievance remains unresolved after 30 days. Within the next six months, you may apply to the Department for IMR, or later, if the Department agrees to extend the application deadline. If your grievance requires expedited review you may bring it immediately to the Department’s attention. The Department may waive the requirement that you follow MHN’s grievance process in extraordinary and compelling cases. If your case is eligible for IMR, the dispute

will be submitted to a medical specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in your case from the IMR. If the IMR determines the service is Medically Necessary, MHN must provide the Disputed Health Care Service. If your case is not eligible for IMR, the Department will advise you of your alternatives.

For *non-urgent cases*, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the application for review and the supporting documents. For *urgent cases* involving imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three business days.

Experimental or Investigational Therapy: If MHN's decision involves a delay, denial or modification of health care services related to a denial of coverage for an **Experimental or Investigational Therapy**, such decision is subject to the IMR process, and MHN will, within five business days of MHN's decision to deny coverage, send a written determination to the Member notifying the Member of his/her right to submit an application for IMR to the Department. The Department does not require Member participation in MHN's grievance system prior to seeking IMR for a denial of an Experimental or Investigational Therapy. In order to receive IMR through the Department the Member must meet all of the following criteria:

1. The Member must have a Life-threatening or Seriously Debilitating condition. For purposes of independent review, "*life-threatening*" means either or both (i) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, and/or (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. The Member's Participating Provider must certify that the Member has a disease or condition, as defined in (1) above, for which (i) standard therapies have not been effective in improving the condition of the Member, (ii) standard therapies would not be medically appropriate for the Member, or (iii) there is no more beneficial standard therapy covered by MHN than the therapy proposed.
3. Either (a) the Member's Participating Provider has recommended a drug, device, procedure or other therapy that the Participating Provider certifies in writing is likely to be more beneficial than any available standard therapies, or (b) the Member's provider who is *not* under contract with MHN, but is appropriately licensed and qualified to treat the Member's condition, has requested a therapy that, based upon two documents from the Medical and Scientific Evidence, is likely to be more beneficial than standard therapies.
4. The specific drug, device, procedure or other therapy recommended would be a Covered Service except for MHN's determination that it is an Experimental or Investigational Therapy.
5. If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination based on relevant Medical and Scientific Evidence of whether or not the care is Medically Necessary. You will receive a copy of the assessment

made in your case from the IMR. If the IMR determines the service is Medically Necessary, MHN must provide the Disputed Health Care Service. If your case is not eligible for IMR, the Department will advise you of your alternatives.

Arbitration

Sometimes disputes or disagreements may arise between you (including your enrolled family members, heirs or personal representatives) and MHN regarding the construction, interpretation, performance or breach of this Evidence of Coverage, or regarding other matters relating to or arising out of your membership in this Plan. Typically such disputes are handled and resolved through the MHN Grievance and Appeal Process described above. However, in the event that a dispute is not resolved in that process, MHN uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with MHN involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to becoming a MHN Member, you agree to submit all disputes you may have with MHN, except those described below, to final and binding arbitration. Likewise, MHN agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and MHN are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by MHN's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

MHN's binding arbitration process is conducted by selection of mutually acceptable arbitrator(s). The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that total amount of damages claimed is \$200,000 or less, the parties shall, within 60 days of the demand for arbitration to MHN, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than \$200,000. In the event that total amount of damages is over \$200,000, the parties shall, within 60 days of the demand for arbitration to MHN, appoint a panel of three neutral arbitrators (unless less than three is mutually agreed upon), who shall hear and decide the case.

Arbitration can be initiated by submitting a demand for arbitration to MHN at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Litigation Administrator
21650 Oxnard Street, #2125
Woodland Hills, CA. 91367-4901

Upon receipt of a demand for arbitration by MHN, the parties will have 60 days to attempt to reach an agreement to select mutually acceptable arbitrator(s) as outlined above. If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of

Competent Jurisdiction for appointment of the arbitrator(s) who would hear and decide the matter.

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this Evidence of Coverage, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law, and that award will be binding on all parties. The parties will share equally the arbitrator's fee involved in the arbitration. Each party also will be responsible for their own attorneys' fees.

In cases of extreme hardship to a Member, MHN may assume all or a portion of a Member's share of the fees and expenses of the arbitration. Upon written notice by the Member requesting a hardship application, MHN will forward the request to an independent professional dispute resolution organization for a determination. Such a request for hardship should be submitted to the Litigation Administrator at the address provided above.

Effective for plan years beginning on and after July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are *not* required to submit disputes about certain "adverse benefit determinations" made by MHN to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by MHN to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and MHN may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Complaints and Grievances

As a condition of enrollment and a contractual term of the Agreement and this Evidence of Coverage, Members are required to submit all grievances through MHN's grievance procedures. MHN's grievance procedures, as specified below, must be completed before the Member may file for any legal action or arbitration, as described above, to receive a final and binding resolution of the grievance.

Please note: After participating in MHN's grievance and/or appeals process for a period of thirty (30) days (or three days for emergency grievances), the Member has the right to file a request for assistance with the Department. When MHN has notice of a case involving imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, MHN provides the following: (a) immediate notification to the Member of their right to notify the Department of the grievance, and (b) no later than three days from receipt of the notice of such grievance request, a written statement to the Member and the Department on the disposition or pending status of the grievance. See Section entitled "The Department of Managed Health Care."

Grievance Process

1. Grievances may be filed with any MHN staff member, in writing, on-line at www.mhn.com or by calling MHN. You may call MHN at 1-800-777-9355, or write to:

MHN *Quality Management Department*
1600 Los Gamos Drive, Suite 300
San Rafael, CA 94903-1807

2. MHN staff members document grievances by filling out an MHN Grievance Report Form.
3. Grievances involving quality of care are investigated and resolved by MHN Quality Management staff.
4. All written grievances are acknowledged by the Quality Management department in writing within five (5) days of MHN's receipt of the grievance.
5. All grievances are resolved within thirty (30) days of MHN's receipt of the grievance, unless the Member is notified within 30 days that additional time is required and the reason for the delay is documented.
7. Members are notified in writing of the resolution of the grievance.
8. For grievances where resolution information can be given, if the Member is dissatisfied with the outcome of the grievance, he/she can appeal by writing to:

MHN
Quality Management Department
1600 Los Gamos Drive, Suite 300
San Rafael, CA 94903-1807

The Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating healthcare service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-777-9355**, and use the plan's grievance process before contacting the Department of Managed Health Care. Utilizing this grievance procedure does not prohibit any potential legal rights 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 30 days, you may call the Department of Managed Health Care. 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 treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The Department of Managed Health Care has a toll-free telephone number (**1-888-HMO-2219 [1-888-466-2219]**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's Internet website (**<http://www.hmohelp.ca.gov>**) has complaint forms, IMR application forms and instructions online.

Second Opinion for Members

MHN may, as a condition of coverage, require that a Member obtain a second opinion from an Appropriately Participating Qualified Health Care Practitioner to verify the Medical Necessity or appropriateness of a Covered Service. In addition, you, as a Member, have the right to request a second opinion when:

- You are concerned about your Participating Practitioner’s diagnosis or Treatment Plan.
- You are not satisfied with the result of the treatment rendered.
- You question the reasonableness or necessity of recommended surgical procedures.
- You question a diagnosis or plan of care for a condition that threatens loss of life, limb, bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
- The clinical indications are complex or confusing, a diagnosis is in doubt due to conflicting test results, or the Participating Practitioner is unable to diagnose the condition.
- The Treatment Plan in progress is not improving your medical condition within an appropriate period of time for the diagnosis and plan of care.
- If you have attempted to follow the plan of care or consulted with the initial Participating Practitioner due to serious concerns about the diagnosis or plan of care.

To request an Authorization for a second opinion, contact your Participating Practitioner or MHN. MHN will review the request, and if a second opinion is considered Medically Necessary and appropriate, MHN will authorize a referral to an Appropriately Qualified Participating Health Care Practitioner. The Practitioner rendering the second opinion will provide a written consultation report to MHN, the Member and the original Participating Practitioner.

When MHN requests a second opinion, it will cover all related charges, including applicable Member Copayments. When a Member requests a second opinion, he/she is responsible for any applicable Copayments.

If the Member faces an imminent and serious threat to health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness would be detrimental to the ability to regain maximum function, the second opinion will be rendered in a timely fashion appropriate to the nature of the condition not to exceed 72 hours of MHN's receipt of the request, whenever possible. For a complete copy of this policy, contact MHN at 1-800-777-9355.

About Our Providers

Choice of Participating Providers

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

MHN offers members a network of Participating Providers that include:

- Psychiatrists
- Psychologists
- Clinical social workers
- Marriage and Family Therapists
- Masters level counselors
- Chemical dependency, rehabilitation and mental health facilities

Provider Information

MHN maintains a database of information on Participating Providers, including their address, telephone number, professional degree, board certification and subspecialty qualifications. If you have questions regarding any of our Participating Providers, or you would like a list of Participating Providers located within your geographic area, you can call us at 1-800-777-9355. You may also view and print a list of MHN's Participating Providers via our website at www.MHN.com. MHN's roster of Participating Providers is subject to change. Although MHN updates our website on a weekly basis so that the information includes only providers currently available to service members, we cannot guarantee the initial or continued availability of any particular Participating Provider.

Remember that all Covered Services must be provided by a Participating Practitioner or Participating Facility Provider. For Authorization and a referral to an MHN Participating Practitioner or Participating Facility Provider, please call MHN at 1-800-777-9355. Exceptions to this rule are cases of an Emergency, if Authorization is provided in writing by MHN's Medical Director or his/her designee, or as otherwise permitted under this Plan.

Can I Change Practitioners?

When you call MHN, every attempt is made to help you select a Participating Provider who will best meet your needs. If you are dissatisfied with the Participating Provider, you may call us for a referral to another Participating Provider. There may also be times when you require care that your initial Participating Provider is unable to administer. In this case, just call MHN or have your Participating Provider call us and we will make a referral to another Participating Provider.

Continuity of Care

New Members: If your Employer or Group has changed health plans and you were receiving services from a non- Participating Provider for a current episode involving an Acute, chronic or serious mental health condition, MHN may, if certain other criteria are met, authorize continuing services from your non- Participating Provider. This decision is determined by MHN, in consultation with the Member and the non-Participating Provider, and consistent with good professional practice. If authorized, MHN will provide a reasonable transition period for you to continue your course of treatment with the non- Participating Provider prior to transferring to a Participating Provider. The length of the transition period takes into account on a case-by-case basis, the severity of the Member's condition and the amount of time necessary to effect a safe transfer, and reasonable consideration is given to the potential clinical effect of a change of provider on the Member's treatment for the condition. MHN may require a non- Participating Provider whose services are continued for a newly covered Member to agree in writing to be subject to the same terms and conditions that are imposed upon Participating Providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the non- Participating Provider, including, but not limited to, rates, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements. The Member's copayments, deductibles or other cost-sharing requirements will be the same as they would be if the Member were receiving care from a Participating Provider.

Among other limitations, new member continuity of care services do not apply if you were offered and refused an out-of-network option by your Employer, or if you had the option to

continue with your previous health plan or non-Participating Provider and instead voluntarily chose to change health plans, or if the non-Participating Provider does not agree to abide by the terms and conditions contained in MHN's standard participating provider contract.

If you feel that you are in need of continuity of care services or if you would like a copy of MHN's new member continuity of care policy, please contact MHN at 1-800-777-9355.

Members Whose Practitioner's Contract Has Been Terminated or Not Renewed: If you are receiving care for an Acute or serious chronic condition and your Participating Practitioner's contract is terminated or not renewed, you may call MHN at the telephone number in this booklet and request continuing care by your Participating Practitioner for Medically Necessary Services, provided you are still eligible. Continuing care may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, not to exceed twelve (12) months in the case of serious and chronic conditions. This decision is determined by MHN, in consultation with the terminated Practitioner, and consistent with good professional practice.

MHN may require the terminated Practitioner whose services are continued beyond the contract termination date to agree in writing to be subject to the same contractual terms and conditions that were in effect prior to termination. This includes, but is not limited to rates, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.

If the terminated Practitioner does not agree to comply or does not comply with MHN's contractual terms and conditions, MHN will not be obligated to continue the Practitioner's services beyond the contract termination date. Further, if the terminated Practitioner voluntarily terminates his or her contract, MHN is not obligated to continue the Practitioner's services beyond the contract termination date.

Your copayments, deductibles, or other cost-sharing components during the period of continuation of care with a terminated Practitioner will be the same amount that you would have paid when receiving care from a currently contracted Participating Practitioner. Your Practitioner must agree to accept MHN reimbursement as payment in full for Covered Services.

MHN will not provide continuing care by a Practitioner whose contract with MHN has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code, fraud or other criminal activity.

MHN also will not cover services or provide benefits that are not otherwise covered under the terms and conditions of this Plan.

Provider Compensation

Generally, MHN compensates its Participating Providers on a fee-for-service basis. MHN does not compensate Participating Providers with bonuses or financial incentives related to the amount of services you may receive under this Plan.

Payment & Claims Information

You do not need to complete claim forms. Just pay your Copayment directly to your Participating Provider.

Prepayment Fees

Your Employer or Group is responsible for paying Prepayment Fees on time and collecting any applicable Member Prepayment Fees due to MHN. If you are required to pay any part of the Prepayment Fee, your Employer or Group will notify you. You may obtain information regarding Prepayment Fees and any necessary payroll deductions from your Employer or Group. MHN will contact your Employer or Group at least thirty (30) days in advance of any change to the premium payment requirements.

Member's Liability for Payment

Members Using Participating Provider Benefits: When a Member receives Covered Services from a Participating Provider, the Member is responsible for any applicable Copayments and for payments for non-Covered Services or benefits that exceed specified limitations. MHN's participating provider agreements stipulate that, in the event MHN fails to pay the Participating Provider, you and your Dependents will not be responsible to the Participating Provider for any sums owed by MHN. There will be no coverage for services provided by non-Participating Providers unless specifically authorized in writing by MHN or otherwise stated on the Benefits Chart at the back of this booklet.

Other Charges

Copayments, coinsurance and deductibles are a Member's share of the costs for Covered Services, which are paid directly to the Participating Provider at the time care is rendered. The specific Copayment, coinsurance and deductible amounts, if any, that apply to Covered Services are listed on the Benefit Chart in the Appendix section of this booklet.

Exclusions

This section details the services and treatments MHN will not cover. This list is not intended to be exhaustive; other limitations and exclusions may apply. Please read these Exclusions carefully before seeking any counseling or treatment through MHN.

EAP

You are eligible to receive a specified number of counseling Sessions, as described in the Benefit Chart in the Appendix section of this booklet. However, the EAP benefit does **not** provide coverage for Inpatient treatment of any kind, or:

- Prescription drugs.
- Counseling required by law or a court, or paid for by Workers' Compensation.
- Formal psychological evaluations and fitness-for-duty opinions.
- Inpatient treatment of any kind

Behavioral Healthcare Services

MHN administers Behavioral Healthcare Services in accordance with the Benefit Chart outlined in the back section of this booklet. However, MHN does not provide coverage for:

- Court-ordered testing and treatment, except when Medically Necessary and within the allowable visits under the Plan contract.
- Private Hospital rooms and/or private duty nursing, unless determined to be a Medically Necessary Service and Authorization from MHN is obtained.
- Ancillary services such as:
 - a. Vocational rehabilitation and other rehabilitation services.
 - b. Behavioral training.
 - c. Speech or occupational therapy.
 - d. Sleep therapy and employment counseling.
 - e. Training or educational therapy or services.
 - f. Other education services.
 - g. Nutrition services
- Treatment by providers other than those within licensing categories then recognized by MHN as providing Medically Necessary Services in accordance with applicable medical community standards.
- Services in excess of those with respect to which Authorization by MHN is obtained.
- Psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated computer based reports.
- All prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a Practitioner in connection with Inpatient treatment.
- Inpatient services, treatment, or supplies rendered without Authorization, except in the event of Emergency Services and Care.
- Healthcare services, treatment, or supplies rendered in a non-Emergency by a provider who is not a Participating Provider, unless Authorization by MHN has been received or as otherwise provided by the Plan.
- Damage to a hospital or facility caused by the Member.
- Healthcare services, treatment or supplies determined to be Experimental by MHN in accordance with accepted mental health standards, except as otherwise required by law.
- Treatment for biofeedback, acupuncture or hypnotherapy.
- Healthcare services, treatment, or supplies rendered to the Member which are not Medically Necessary Services. This includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, Custodial Care or Domiciliary Care as determined by MHN.
- Services received before the Member's effective date, during an Inpatient stay that began before the Member's effective date or services received after the Member's coverage ended, except as specifically stated herein.

- Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage.
- Services performed in any emergency room which are not directly related to the treatment of a Mental Disorder.
- Services received out of the Member's primary state of residence except in the event of Emergency Services and Care and as otherwise authorized by MHN.
- Electro-Convulsive Therapy (ECT) except as authorized by MHN according to MHN policies and procedures.
- All other services, confinements, treatments or supplies not provided primarily for the treatment of specific covered benefits outlined in the "Benefit Chart" and/or specifically included as Covered Services elsewhere in this Plan.

Coordination of Benefits

When a Member is covered under this Plan and any Other Plan, coverage under this Plan is coordinated with the benefits of the Other Plan so that the combination of the two plans will not provide benefits exceeding the expenses incurred.

MHN reserves the right to obtain reimbursement from such Other Plan for the value of the services provided. Members are responsible to facilitate such payment to MHN or any of its Participating Providers.

In determining the primary and secondary carrier responsibility for benefits with the Other Plan, MHN uses the guidelines of the Agreement and any applicable laws and regulations.

Termination of Coverage

Termination of Agreement

The Agreement between MHN and your Employer or Group specifies how long the Plan remains in effect and under what conditions your Employer or Group may terminate the Agreement.

MHN may terminate the Agreement for non-payment of Prepayment Fees and for any other reason specified in the Agreement. If Prepayment Fees are not paid according to the Agreement, termination is effective fifteen (15) days after the termination notice is mailed to the Employer or Group.

If the Agreement is cancelled for the Employer or Group's non-payment of Prepayment Fees, MHN will permit reinstatement of the Agreement once during any twelve (12) month period if the Employer or Group pays all required Prepayment Fees within fifteen (15) days of the date of notice of termination.

Upon termination of the Agreement by either party, your Employer or Group is responsible for notifying you about the change in coverage.

Termination of Member's Benefits

MHN may **immediately** terminate the coverage of a Member upon notice that the Member:

- Provided false or misleading information; or omitted or failed to provide true and accurate information to the Employer or Group or MHN.
- Obtained or attempted to obtain services or benefits by means of false, misleading, or fraudulent information, acts, or omissions.
- Assisted a person who is not a Member to obtain services.
- Assaulted, or threatened the life or well-being of MHN's staff, the Practitioner or their affiliated personnel, a Facility or a Facility's personnel, or any other Member.
- Repeatedly behaved in a manner that substantially impairs the ability of MHN to furnish or arrange for the provision of services for Members or Providers.

Termination of coverage for the Subscriber automatically terminates coverage for his/her Dependents. If a Subscriber ceases to be eligible according to the provisions listed in the Agreement, coverage will be terminated for the Subscriber and any enrolled Dependents effective on midnight of the last day of the month in which such event occurred.

If a Dependent ceases to be eligible according to the provisions of the Agreement, coverage will only be terminated for that person – effective on midnight of the last day of the month in which the loss of eligibility occurred.

For California Members only: If you feel that your coverage was canceled, or your renewal was denied because of your health status or requirements for healthcare services, you may request a review of any such termination or denial by the California Department of Managed Health Care (the "Department"). The Department's toll-free number is **888-HMO-2219** (888-466-2219).

Renewal Provisions

This Plan automatically renews on the anniversary date of the Agreement, unless notice of termination is served within the time specified or as otherwise provided in the Agreement. However, MHN may change its fees, benefits, or the terms of the Agreement on the anniversary date of this Plan, unless otherwise mandated by law.

Continuation of Coverage

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), a Member who loses coverage under this Plan is entitled under certain conditions to elect to continue group coverage if the Employer or Group is not exempted under COBRA. California law provides that an employee and his or her spouse who qualified for COBRA coverage following termination of employment may be entitled to additional COBRA-like coverage ("Cal-COBRA"). Please check with your Employer or Group to determine if you are eligible for COBRA and/or Cal-COBRA and see additional disclosures below.

Generally, COBRA requires all employers or groups of 20 or more employees to offer to continue group coverage for up to 18 months to employees and their Dependents who lose coverage due to termination of employment (except for gross misconduct) or reduction in hours worked, and for up to 36 months to Dependents who lose coverage due to the death of the employee, divorce or legal separation from the employee or to children who no longer qualify as covered Dependents.

“Extended” coverage of up to 29 months is available to certain COBRA beneficiaries who are disabled at the time of their qualifying event and entitled to Social Security disability benefits. Continuation of group coverage rights under COBRA continue until either the exhaustion of the maximum continuation periods or a “terminating event” occurs (e.g., termination of all group plans provided by Employer or Group, failure of Member to pay monthly Prepayment Fees when due, the Member is or becomes covered under any other group plan without limitation as to the totally disabling condition, or the Member is or becomes entitled to Medicare coverage).

Benefits of the continuation plan are identical to this Plan. The cost of the coverage will be 102% of the applicable group rate (including any portion previously paid by Employer or Group) during the period of basic COBRA coverage and 150% of the applicable group rate during the period of “extended” coverage (i.e., 19th through 29th month for disabled beneficiaries).

UNDER COBRA, THE EMPLOYER OR GROUP IS SOLELY RESPONSIBLE FOR ALL NOTIFICATION, ADMINISTRATION, AND OTHER COMPLIANCE

RESPONSIBILITIES. Please consult with your Employer or Group for questions regarding continuation of group coverage. You should receive notice from your Employer or Group plan administrator of your eligibility for group continuation coverage if a qualifying event occurs. In the event of a Subscriber’s death, this notice should be sent to the Subscriber’s Dependents.

Failure of a Subscriber or affected Dependents to notify Employer or Group within 60 days of a divorce, legal separation or a Dependent child’s loss of eligibility will result in loss of eligibility for group continuation coverage. The Employer or Group must notify MHN of the occurrence and related date of any qualifying event within thirty (30) days of the incident. If the Member fails to provide such notice to the Employer or Group, then the Member will not be entitled to continuation coverage under this Plan.

COBRA coverage will begin at the time group coverage ends if you apply and pay the required Prepayment Fees within 60 days after receiving notice of eligibility for continuation coverage or the date of loss of coverage, whichever is later. If you elect to continue coverage within the time required, your coverage will be retroactively reinstated to the date you or your Dependents were last covered under the Agreement. Any Prepayment Fees for retroactive coverage must be paid to MHN no later than 45 days from the date you elect to continue coverage. You will be billed for current coverage monthly by your Employer or Group. Your Employer or Group must pay Prepayment Fees to MHN by the 20th day of each month prior to the month of coverage.

Coverage will be canceled on midnight of the last day for which payment was last made if Prepayment Fees are not received within 30 days of the due date.

Members who are Dependents will be offered the same services and benefits as are offered to Subscribers. If the group health plan of a Group is changed, these changes will be applied to the Subscribers and Dependents who have properly elected continuation coverage pursuant to this

provision. There will be no interruption or lapse in coverage for a Subscriber or Dependent who properly elects continuation coverage, provided that all Prepayment Fees are paid to and received by MHN on time. If a Subscriber or Dependent does not elect continuation coverage hereunder or fails to pay premiums for continuation coverage as required by this Section, the Subscriber or Dependent will be responsible for payment to MHN on a fee-for-service basis of all charges for services and benefits provided to the Subscriber or Dependent by MHN, if any, following the date on which the Subscriber or Dependent ceases to be eligible for Covered Services under the Agreement.

Additional Cal-COBRA Disclosures

Note: If you have a qualifying event as explained above, elected COBRA coverage on or after January 1, 2003, have exhausted federal COBRA coverage and have had less than 36 months of COBRA coverage, you may have the opportunity to continue coverage through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began. You must also notify your Employer or Group of the following qualifying events:

- The death of the covered Subscriber.
- The divorce or legal separation of the covered Subscriber from the covered Subscriber's spouse.
- The loss of dependent status by a Dependent enrolled in the Plan.
- With respect to a covered Dependent only, the covered Subscriber's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

Please contact your Employer or Group to determine if you are eligible for extended Cal-COBRA coverage.

You must request the continuation coverage in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the Group within the 60-day period following the later of (1) the date your coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date you were sent notice of the ability to continue coverage under the group benefit plan.

The notice will state the amount of the Prepayment Fees you are required to pay MHN. The first Prepayment Fee required to establish premium payment must be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to MHN, within 45 days of the date you provided written notice of your election to continue coverage. The first Prepayment Fee must be equal to an amount sufficient to pay any required premiums and all premiums due. In the event that your continuation coverage terminates under a prior group benefit plan, you may continue your coverage for the balance of the period that you would have remained covered under the prior group benefit plan, including the requirements for election and payment.

Payment For Cal-COBRA

The Member must pay MHN 110% of the applicable group rate charged for employees and their dependents. If the maximum period of coverage is extended beyond the initial 18 months for an additional 11 months due to a determination by the Social Security Administration that the Qualified Beneficiary is totally disabled, pursuant to Title II or Title XVI of the Social Security Act, the Member must pay 150% of the applicable group rate for the additional 11 months of coverage.

Disqualifying Events

- Continuation coverage will terminate if you fail to comply with the requirements pertaining to enrollment in, and payment of Prepayment Fees to, MHN within 30 days of receiving notice of the termination of the prior group benefit plan.
- Failure to submit the correct Prepayment Fee amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this provision.
- Your employer ceases to provide group benefits to his or her employees.
- You move out of your plan's service area.
- You commit fraud or deception in the use of Plan services.

Other Things to Know

The Independent Contractor Relationship

The relationship between MHN and Participating Providers is that of an independent contractor. Participating Providers are not agents or employees of MHN, nor is MHN and/or its employees and agents an employee or agent of any Participating Provider. MHN and its Participating Providers are not authorized to represent each other for any purposes, nor are they or any of their respective officers, agents or employees to be construed to be officers, agents or employees of the other. Participating Providers maintain the provider-patient relationship with Members and are solely responsible to Members for all services they provide to Members. In no event shall MHN be liable for negligence, wrongful acts or omissions of Participating Providers.

MHN and your Employer or Group are independent contractors in relation to one another and no joint venture, partnership, employment, agency or other relationship is created by the Agreement. Neither MHN nor your Employer or Group are liable for any act, negligence or omission of the other, nor are they each other's agents or employees. Neither MHN nor your Employer or Group is authorized to represent the other for any purpose. None of the parties to the Agreement nor any of their respective officers, agents or employees shall be construed to be the officer, agent or employee of any other party.

Regulations

MHN is licensed in the State of California as a specialized healthcare service plan and regulated by the California Department of Managed Health Care. As such, MHN is subject to the requirements of the Knox-Keene Health Care Service Plan Act (the "Act"). Any provisions required to be in this Evidence of Coverage by the Act or by law shall bind MHN whether or not provided in this Evidence of Coverage.

Public Policy

MHN permits Members to participate in establishing its public policy through its Public Policy Committee – the findings and recommendations of which are regularly reported to MHN’s governing Board of Directors. For the purposes of description, “public policy” means acts performed by MHN and its employees to assure the comfort, dignity and convenience of Members who rely on Participating Providers to provide Covered Services.

Non-Assignability of Benefits

Members cannot transfer the coverage and benefits of this Plan to another person without the prior written consent of MHN. Such a request may be denied for any reason. MHN reserves the right to make payment of benefits, at its sole discretion, directly to the Participating Provider or to the Member.

Organ Donation

Organ donation can extend and enhance lives and is an option you may want to consider. For more information on the subject, please contact the U.S. Department of Health and Human Services.

Antifraud Plan

MHN maintains a toll-free Fraud & Abuse Hotline at (800) 327-0566 where members, practitioners and employees can refer suspected fraudulent activity in the submission of claims.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which Managed Health Network (“MHN”) (referred to as “we” or “the Plan”) may collect, use and disclose your protected health information and your rights concerning your protected health information. “Protected health information” is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

- **Payment.** We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.
- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service. In some cases, we may use or disclose the information for underwriting or determining premiums.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, mental health practitioners, pharmacies, hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** If you are enrolled through a group health plan, we may provide non-identifiable summaries of claims and expenses for enrollees in your group health plan to the plan sponsor, which is usually the employer. If the plan sponsor provides plan administration services, we may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. MHN will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.
- **Enrolled Dependents and Family Members.** We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for the subscriber of the health plan.

OTHER PERMITTED OR REQUIRED DISCLOSURES

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., state insurance departments) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

OTHER USES OR DISCLOSURES WITH AN AUTHORIZATION

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have certain rights regarding protected health information that the Plan maintains about you.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
- **Right To Amend Your Protected Health Information.** If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend

information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.

- If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.
- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.
- **Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. *We may not agree to your request.* If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
- **Right To Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.

HEALTH INFORMATION SECURITY

MHN requires its employees to follow the MHN security policies and procedures that limit access to health information about members to those employees who need it to perform their job responsibilities. In addition, MHN maintains physical, administrative and technical security measures to safeguard your protected health information.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our website at www.MHN.com. Any time we make a material change to this Notice, we will promptly revise and post the new Notice with the new effective date.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the privacy office listed at the end of this Notice. We support your right to protect the privacy of your protected health information. ***We will not retaliate against you or penalize you for filing a complaint.***

CONTACT THE PLAN

If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, please contact:

MHN
Legal Department
1600 Los Gatos Drive, Suite 300
San Rafael, CA 94903-1807
(800) 533-3719, ext. 7232

Definitions

Whenever the following definitions are capitalized in this Evidence of Coverage, they will have the meaning stated below:

Acute: Sudden onset or abrupt change of a mental health condition requiring prompt attention, but which is of limited duration, as determined by MHN.

Agreement: Includes the agreement between MHN and Employer or Group, this Evidence of Coverage and any addenda and/or amendments thereto.

Alternate Treatment: A planned, medical therapeutic program for persons with Mental Disorders. This includes diagnosis, medical care, and treatment when the patient does not require full-time hospitalization, but does need more intensive care than traditional Outpatient visits.

Appeal Process: The formal process by which MHN offers a mechanism to review a denial or Disputed Health Care Service. Appeals may be requested orally or in writing by the Member, a person acting on behalf of the Member or the Member's Participating Provider.

Appropriately Qualified Participating Health Care Practitioner: A licensed health care Practitioner who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Authorization: A decision in writing by MHN's Medical Director or his/her designee that the services that a Member will receive or has received under a particular Plan meet MHN clinical criteria. Requests for Authorization will be denied if not Medically Necessary, if in conflict with MHN's policies or are otherwise not covered under the Plan. The actual payment of benefits is determined by eligibility at the time services were rendered, Authorization, and available Benefits.

Behavioral Healthcare Services: Chemical Dependency, Substance Abuse and/or Mental Healthcare Services determined by MHN to be Covered Services under this Plan.

Benefits: Benefits are set forth in the Benefit Chart in the Appendix section of this booklet.

Chemical Dependency or Substance Abuse: Psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and treatment.

Combined Evidence of Coverage and Disclosure Form: A document issued by MHN or another licensed health plan or insurer to a Member that describes the specific Covered Services under the applicable Plan.

Complaint: Any expression of dissatisfaction from a member, whether received in writing or on the telephone.

Continuity of Care: The provision of managed and organized healthcare that will facilitate the continuity of Covered Services in a timely manner to Members.

Coordination of Benefits: The coordination of the payment of benefits between two or more payors of benefits, on a primary or secondary payor basis, to avoid duplication of benefit payments as provided in the Agreement.

Copayment: The payment to be collected directly by the Participating Practitioner or Participating Facility Provider from the Member for Covered Services, excluding permitted Deductibles, if any.

Covered Services: Chemical Dependency, Substance Abuse or Mental Healthcare Services which constitute the Benefits that are covered under this Plan. The determination of whether a benefit is a Covered Service rests with MHN.

Custodial Care: Care rendered to a Member who meets any of the following conditions:

- Disabled mentally or physically and such disability is expected to continue and be prolonged.
- Requires a protected, monitored, or controlled environment whether in an institution or in a home.
- Requires assistance to support the essentials of daily living.
- Not under active and specific psychiatric treatment that will reduce the disability to the extent necessary to enable the Member to function outside the protected, monitored, or controlled environment.

A determination that Custodial Care is required is not precluded by the fact that a Member is under the care of a supervising or attending physician or other Participating Practitioner and that services are being ordered and prescribed to support and generally maintain the Member's condition, provide for the Member's comfort, or ensure the manageability of the Member.

Dependent: Any person who is the legal spouse of a Subscriber, or a dependent child of a Subscriber or Subscriber's spouse, who otherwise meets the eligibility requirements established for Dependents under the Agreement and this Evidence of Coverage and is enrolled in the Plan.

Deductible: That portion of the cost of Covered Services, if any, required under this Plan to be paid by the Member prior to any liability for payment by MHN.

Diagnostic and Statistical Manual of Mental Disorders (DSM): A listing of diagnostic categories and criteria which provides guidelines for making diagnoses of Mental Disorders. The DSM is a widely accepted basis for describing the presence and type of these disorders. A DSM diagnosis of Mental Disorder is a minimum requirement for the demonstration of Medical Necessity. The diagnosis must be contained in the most recent edition of the DSM.

Disputed Health Care Service: Any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its Participating Providers, in whole or in part due to a finding that the service is not Medically Necessary.

Domiciliary Care: Inpatient institutional care provided to the Member not because it is Medically Necessary, but because care in the home setting is not available, is unsuitable, or

members of the patient's family are unwilling to provide the care. Institutionalization because of abandonment constitutes Domiciliary Care.

Emergency or Emergency Admission or Psychiatric Emergency Medical Condition: The sudden onset of a condition manifesting itself by Acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson possessing an average knowledge of medicine and health, could reasonably expect in the absence of immediate Behavioral Healthcare Services, could reasonably result in:

1. serious impairment to bodily functions;
2. placing the health of the Member, or others, in serious jeopardy; or
3. serious dysfunction of any bodily organ or part.

Emergency Services and Care: Screening, examination and evaluation by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, within the capability of the Facility.

Employer or Group: An employer, trust fund, licensed health plan or insurer, or other group or business entity that has contracted with MHN for the provision of Behavioral Healthcare Services to Members.

Episode: An Episode is a course of treatment or program voluntarily undertaken for Chemical Dependency or Substance Abuse. Each course of treatment will count as one (1) Episode if the Member resumes interrupted treatment within 30 days of leaving treatment. If the return to treatment requires return to a higher level of care, this would be a second Episode.

Experimental (also "Experimental or Investigational Therapy"): Medical care that is essentially investigatory or an unproven procedure or treatment regimen that does not meet the generally accepted standards of usual professional medical or mental health practice in the general professional community, unless otherwise deemed appropriate by an Independent Medical Review organization.

Facility: A health or residential treatment center 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.

Grievance: A complaint that is handled through the complaint process or an appeal that is handled through the Appeal Process.

Hospital: Any duly licensed and accredited Acute care psychiatric Facility or psychiatric unit in a general Acute care Hospital which provides Inpatient care and is engaged in providing facilities and services for the diagnosis and treatment of Mental Disorders.

Independent Medical Review ("IMR"): Certain jurisdictions, including California, establish independent medical review procedures to provide independent medical review of appeals denied by health care service plans on the basis of Medical Necessity or because the service is an Experimental or Investigational Therapy. In those jurisdictions, MHN provides notices of IMR in compliance with legal regulations.

Inpatient: A Member who has been admitted to a Hospital or other authorized institution for bed occupancy for purposes of receiving necessary Behavioral Healthcare Services, with the reasonable expectation that the Member will remain in the institution at least 24 hours.

Medical and Scientific Evidence: means the following sources:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS data base Health Services Technology Assessment Research (HSTAR).
3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.
4. The following standard reference compendia: The American Hospital Formulary Service Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information.
5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institute of Health for the purpose of evaluating the medical value of health services.
6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

Medical Director: A physician licensed to practice medicine in the state of California and employed by MHN to coordinate and monitor the Quality Management, Utilization Management, and Practitioner services for MHN.

Medically Necessary Service (also "Medically Necessary" or "Medical Necessity"): A Medically Necessary Service describes psychiatric and/or other related health care services proposed by Participating Providers, which must meet all of the following conditions as determined by MHN:

- The requested services provide for the diagnosis and/or active treatment of a covered current DSM Axis I Mental Disorder or substance-related disorder.
- The proposed Treatment Plan represents an active, necessary and appropriate intervention for the timely resolution of the Member's symptoms and the restoration to baseline level of functioning. The proposed services are not primarily Custodial Care or Domiciliary Care in nature.
- The type, level and length of the proposed services and setting are consistent with MHN's level of care criteria and guidelines and are rendered in the least restrictive level of care in which the Member can be safely and effectively treated.
- The proposed treatment is not Experimental in nature unless otherwise deemed appropriate on an individual case by case basis by an Independent Medical Review Organization (IMRO); that is, its safety and efficacy have been clearly demonstrated and widely accepted

in the modern psychiatric literature. A determination by an IMRO that a service is Medically Necessary applies only to that specific request for independent review.

- The proposed Treatment Plan has been demonstrated in peer reviewed journals to be at least equally effective in bringing about a rapid resolution of symptoms when compared to possible alternative treatment interventions.
- The proposed Treatment Plan utilizes clinical services in an efficient manner when compared to alternative treatment interventions and contributes to effective management of the Member's benefit.
- Treatment is provided by a mental health professional licensed to practice independently who meets MHN's credentialing standards.

Member: Any individual who meets all applicable eligibility requirements specified within the Agreement and this Plan, is enrolled under this Plan and for whom all required Prepayment Fees have been received and accepted by MHN.

Mental Disorder: A Mental Disorder is a nervous or mental condition that meets **all** of the following conditions:

- It is a clinically significant behavioral or psychological syndrome or pattern.
- It is associated with a painful symptom, such as distress.
- It impairs a Member's ability to function in one or more major life activities.
- It is a condition listed as an Axis I Disorder in the most recent edition of the DSM by the American Psychiatric Association.

Mental Healthcare Services: Those services determined by MHN to be Medically Necessary Services for the treatment of a Mental Disorder.

Other Plan or Plan: Any of the following Plans that provide full or partial benefits for Behavioral Healthcare Services:

- Group, blanket or franchise insurance coverage.
- Group or Hospital services plan contract, group practice, individual practice and other prepayment coverages.
- Any coverage under labor-management trustee plans, union welfare plans, employer or group organization plans, employee benefit organization plans or self-insured employee benefit plans.
- Any coverage under governmental programs, and any coverage required or provided by any statute.
- The term Other Plan refers separately to each policy, contract or other arrangement for services and benefits, and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the services and benefits of Other Plans into consideration in determining its benefits and that portion which does not.
- This Plan means that portion of the Agreement which provides for the provision of Covered Services for Members.

Outpatient: An ambulatory Member receiving Covered Services who has not been admitted to a Hospital or Facility.

Participating Facility Provider: A Hospital or a Facility that furnishes Behavioral Healthcare Services to Members and has agreed, by signing an agreement with MHN, to accept the provisions of the applicable agreement, including the Facility-specific compensation, as the total charge, whether paid fully by MHN or requiring cost-sharing by the Member.

Participating Practitioner: A professional Practitioner who furnishes Behavioral Healthcare Services to Members and has agreed, by signing a participating provider agreement with MHN, to accept the provisions of the applicable agreement, including the contractually agreed upon compensation, as the total charge, whether paid fully by MHN or requiring cost sharing by the Member.

Participating Provider: A professional Practitioner, Facility or Hospital that furnishes Behavioral Healthcare Services to Members and has agreed, by signing a participating provider agreement with MHN, to accept the provisions of the applicable agreement, including the contractually agreed upon compensation, as the total charge, whether paid fully by MHN or requiring cost sharing by the Member.

Peer Reviewer: MHN psychologists and psychiatrists who conduct peer review of requests that care managers believe do not meet MHN level of care criteria. Psychologists may review the requests by Master's level clinicians as well as psychologists for Outpatient treatment only. Psychiatrists review any Outpatient services by psychiatrists or other mental health practitioners and all Inpatient or Alternate Treatment requests. Only Medical Directors or physician advisors conduct expedited or standard written appeals.

Practitioner: A psychiatrist, licensed psychologist, licensed clinical social worker, marriage family therapist or masters level counselor who is duly licensed or certified under the laws of the State wherein the Practitioner is located.

Preauthorization: Approval for coverage from MHN prior to the Member obtaining Covered Services. Requests for Preauthorization will be denied if the services requested are not Medically Necessary, in conflict with MHN's medical policies, or otherwise not covered under this Plan.

Prepayment Fee: A pre-negotiated fixed monthly fee that is payable to MHN by a Group for each Member who is enrolled with MHN pursuant to the Agreement.

Prudent Layperson: A person who is without clinical training and who draws upon their practical experience when making a decision regarding whether emergency treatment is needed. They are considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observing the clinical symptoms at hand, that emergency treatment was necessary.

Quality Management or Utilization Management Program: A function performed by MHN to review and determine whether the Behavioral Healthcare Services provided, or to be provided, to a Member, meet MHN's standards of quality and are Medically Necessary Services and/or Covered Services.

Serious, chronic condition: A condition due to a disease, illness or other Mental Disorder that is serious in nature, persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration.

Session: Any in-person or telephone consultation with a Practitioner for Covered Services under this Plan.

Subscriber: The covered primary person as defined herein and in the Agreement who is generally an employee of the Employer or Group.

Treatment Plan: A detailed description of the healthcare service, treatment, or supply being rendered or expected to be rendered to a Member. The Treatment Plan must include, but is not limited to:

- A diagnosis (DSM), all Axes.
- Reports of pertinent prior treatment, medical, family, social and work history and/or any diagnostic tests, anticipated frequency and duration of medications and consultations.
- A description of the specific goals of treatment.
- Prognosis and proposed treatment and modality.

Your Benefits as an Employee of *Long Beach Community College District*

Who Is Eligible For Benefits?

The following individuals are eligible for benefits as Subscribers and Dependents:

As an individual who is (1) an eligible employee working 50% (time) or greater, (2) an eligible employee working greater than twenty (20) hours per week or more or (3) a retiree, you are eligible to participate in the Employee Assistance Program. Additionally, your spouse and dependent child of a Subscriber or Subscriber's spouse, who is either: (a) unmarried and age 25 or less OR (b) over the age of 25 and incapable of self-sustaining employment by reason of mental retardation or physical handicap incurred prior to age 26 and chiefly dependent upon the Subscriber or Subscriber's spouse for support and maintenance

When Does Coverage Begin And End?

Your eligibility begins on the first of the month following your date of hire. Your eligibility ends upon termination of employment, or when your employer's contract with MHN is terminated. Your eligible family members are covered during the same time you are.

Upon termination of employment, you and/or your eligible Dependents may continue coverage under COBRA. See section entitled "Continuation of Coverage." Your coverage cannot be cancelled, nor can you be denied renewed coverage, because of your health status or requirements for service. If you think this has happened, you may request a review by the California Department of Managed Health Care. Your coverage can be terminated at any time by MHN for fraud or deception in the use of counseling services.

- ✓ **Note:** If you have qualified for and elected COBRA coverage on or after January 1, 2003, have exhausted federal COBRA coverage and have had less than 36 months of COBRA coverage, you may have the opportunity to continue coverage through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began. Please refer to the "Continuation of Coverage" section of this booklet for more information.

How Can I Contact MHN?

You can call MHN 24 hours a day, 7 days a week, 365 days a year. Your dedicated access number is 1-800-777-9355. MHN staff is available to assist you in obtaining the appropriate referral, answer questions about your benefits or connect you immediately to a staff clinician for a clinical emergency.

Benefit Chart

	In Network	Out of Network
Outpatient Benefit	100% reimbursement of MHN's contracted rate amount	No benefits
Outpatient Maximum Session Max / Year In / Out Combined ? Yes	Unlimited	N/A
Mental Health Inpatient	100% reimbursement	No benefits
Substance Abuse Treatment Penalty for not completing SA Treatment? No	100% reimbursement	No benefits
Concurrent Review Required?	Yes	No
Discharge Planning Required?	Yes	No
Inpatient Maximums Mental Health Days / Dollars Substance Abuse Days / Dollars	MH - none \$5,000 per episode 5 days maximum for detox - Rehab - Alternate care facilities only.	N/A
Detox / Rehab Combined ? Yes		
MH/SA Combined? No		
Substance Abuse Episode Max In / Out Combined? No		
Deductible Individual Family Apply to all services? No	\$250 for substance abuse only	N/A
Out of Pocket Maximum Individual Family Apply to all services? No	None	N/A
Lifetime Maximum Apply to all services? No	2 episodes per lifetime	N/A
Penalty for no pre-authorization?		
Outpatient? Yes	Penalty Description: No benefits payable	Penalty Description: N/A
Mental Health Inpatient Yes	Penalty Description: No benefits payable	Penalty Description: N/A
Substance Abuse Yes	Penalty Description: No benefits payable	Penalty Description: N/A