




Mira Costa College
Group #2888

Behavioral Healthcare Services Combined
Evidence of Coverage and Disclosure Form

 - detach below

 Group # 2888 Plan Code 0M6 To obtain services, please call Managed Health Network (MHN) at(800) 728-9899 for assessment, referral and authorization. Clinical screening and referral to network providers is available 24 hours a day / 7 days a week.	 fold here	Individual/Family Deductible* \$0/\$0 OOP Max* \$1,500/\$3,000 Out-of-Pocket Maximum (OOP)
		members.mhn.com *Combined for medical and Mental Health/ Substance Use Disorder plan 

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of your behavioral healthcare plan. Please consult MHN's behavioral healthcare plan contract with your employer or group to determine the exact terms and conditions of coverage.

Administered by

A Health Net CompanySM

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About This Booklet

What is this Combined Evidence of Coverage and Disclosure Provisions Document?

MHN has combined into this document a description of your Managed Health Network (“MHN”) behavioral healthcare plan benefits (“Evidence of Coverage”) as well as certain disclosures that are required by law (“Combined Evidence of Coverage & Disclosure Form”).

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 the benefits to which you are entitled and 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 behavioral healthcare 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 your 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 **[1-800-728-9899]**.

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.

Table of Contents

Member Rights & Responsibilities	9
As a Member, you have the right to.....	9
As a Member, it is your responsibility to.....	9
Program Overview	10
How the Program Works	10
Important information About Preauthorization	11
Behavioral Healthcare Services	11
How Do I Obtain Behavioral Healthcare Services?	11
Emergency Care.....	11
Non-Emergency Care.....	12
Utilization Review	12
Claiming Benefits	13
Authorization, Modification or Denial of Services.....	13
Definitions.....	13
Rules Applicable to Authorization, Modification or Denial of Services.....	14
Failure to Follow Procedures Regarding Request for Authorization.....	14
Insufficient Information	14
Notice of Determination	14
If the Request for Authorization is Denied.....	15
Appealing a Denial of Services.....	15
MHN Levels of Appeal.....	16
Arbitration.....	19
Complaints and Grievances	20
Grievance Process.....	21
The Department of Managed Health Care	21
Second Opinion for Members	22
About Our Providers	22
Choice of Participating Providers	22
Provider Information.....	23
Can I Change Practitioners?.....	23
Continuity of Care.....	23
Provider Compensation.....	25
Reimbursement and Claims Information	25
Prepayment Fees	25
Member’s Liability for Payment.....	25
Other Charges	25
Exclusions and Limitations of Benefits	26
Coordination of Benefits	28
Termination of Coverage	28
Termination of Agreement.....	28
Termination of Member’s Benefits.....	29
Renewal Provisions.....	29
Continuation of Coverage	29
Other Things to Know	32
The Independent Contractor Relationship	32
Regulations	32
Public Policy	32

Non-Assignability of Benefits33
Organ Donation.....33
Antifraud Plan.....33
Notice of Privacy Practices.....34
Notice of Non-Discrimination35

Definitions.....36
Your Benefits as an Employee of Mira Costa College.....44
Benefit Chart45

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.
- **Protected Individuals are not required to obtain the policyholder, primary subscriber, or other enrollee’s authorization to receive Sensitive Services or to submit a claim for Sensitive Services if you have the right to consent.**
- Obtain an explanation regarding legally required exceptions to confidentiality.
- Receive a clear explanation from your Practitioner about the recommended Treatment Plan and the expected 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 the MHN Member Rights & Responsibilities policies and procedures.
- Receive a complete explanation of your fees and charges.
- Receive a clear explanation of your financial responsibility when you use out-of-network providers.

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.

A copy of the Member Rights & Responsibilities can also be viewed online at <https://members/mhn/com/web/public/default/MemberInformation/RightsAndResponsibilities>.

Program Overview

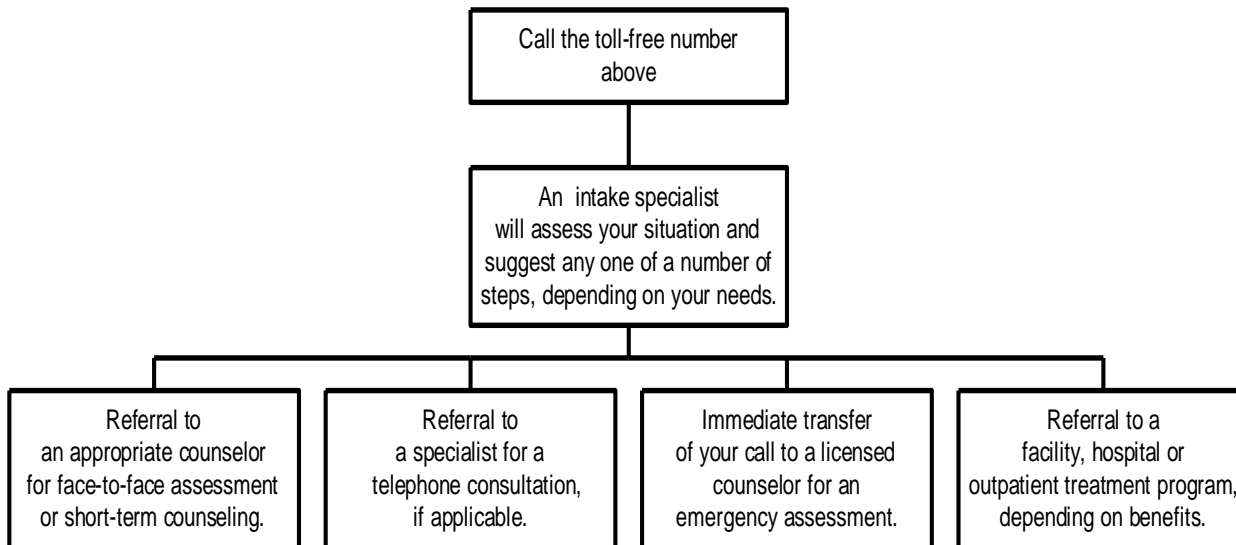
To help you with emotional, stress-related or substance abuse issues, **Mira Costa College** has made available to you and your eligible family members high quality, affordable Behavioral Healthcare Services. These services are provided through MHN's Behavioral Healthcare Services.

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 **[1-800-728-9899]**.

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 before receiving any services – 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. In some cases, a non-Participating Practitioner may provide covered services at Participating Facility where we have authorized you to receive care. You are not responsible for any amounts beyond your cost share for the covered services you receive at Participating Facilities where we have authorized you to receive care.

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.

Behavioral Healthcare Services

MHN arranges for the provision of Inpatient and Outpatient Behavioral Healthcare Services. MHN reviews your mental health and/or Substance Use Disorder 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 listed in the Appendix 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 then review your case to ensure eligibility and appropriateness of treatment.
- ✓ 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 nearby,

MHN will refer you to a non- Participating Provider. In the event that MHN cannot find you a referral, or if it's not feasible to contact MHN, 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. After that time, 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 [1-800-728-9899] 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.

Authorization, Modification or Denial of Services:

The requirements for processing requests for Authorization depend on the type of request submitted. The types of requests are: “urgent”, “pre-service”, “post-service” or concurrent. Here are the definitions of the types of Authorizations, followed by the rules that apply to each type:

DEFINITIONS

Urgent Care: Urgent Care is care or treatment 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. A physician with knowledge of your medical condition must make determinations regarding the severity of pain.

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

Concurrent Care: 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.

RULES APPLICABLE TO AUTHORIZATION, MODIFICATION OR DENIAL OF SERVICES:

Failure To Follow Procedures Regarding Request for Authorization:

If you fail to follow the proper procedures when requesting authorization for Pre-Service, Non-Urgent or Urgent Care, MHN will notify you regarding the proper procedures to be followed to complete the process within:

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

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. However, please note, that a failure to provide such information in a reasonably timely manner may result in the request being denied.

Notice Of Determination

Urgent Care (Pre-Service or Concurrent): MHN will notify you of its decision as soon as possible, taking into account medical exigencies, but not later than 72 hours after MHN's receipt of your Urgent Care request.

If you fail to provide MHN with information sufficient to enable MHN to make a decision, you will be notified as soon as possible, but not later than 24 hours after MHN's receipt of your request for authorization. At that time, MHN will specify the additional information required. You will then have at least 48 hours to provide the specified, missing information. Depending on your circumstances, including illness, you may be given a longer time to provide the missing information. MHN will provide you with its decision on the request for authorization as soon as possible, but in no case later than 48 hours after the earlier of MHN's receipt of the specific information or the end of the period afforded you to provide the specified missing information.

Non-Urgent Request (Pre-Service): MHN will make a decision in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days after MHN's receipt of the information reasonably necessary and requested by MHN to make the determination. If MHN becomes aware that it cannot make a decision within the required time frame because it is not in receipt of all of the information reasonably necessary and requested, or because MHN requires consultation by an expert reviewer, or because MHN has asked that an additional examination or test be performed on the Member (which test is reasonable and consistent with good medical practice), MHN will immediately, within the timeframes specified above in this paragraph, notify the Member, in writing, that it cannot make a decision within the required time frame, and MHN shall specify the information requested, but not received, or the expert reviewer to be consulted, or the additional examinations or tests required, and the anticipated date on which a decision will be rendered.

Non-Urgent Request (Concurrent Care): 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 request. 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, the request will be decided as soon as possible, taking into account the medical exigencies. MHN will notify you of its benefit determination not later than 24 hours after its receipt of the request for authorization, 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 considered Urgent Care, a determination will be made according to the Urgent Care 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 and decided according to Pre-Service or Post-Service time frames, whichever applies.

If the Request for Authorization Is Denied

If a request for authorization 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 request 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 request 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 request, or a statement that a copy will be provided free of charge upon request.
- If your 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 request was an Urgent Care request, a description of the expedited review process is available to you.

Appealing A Denial Of Services:

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 **[1-800-728-9899]**. 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).

- Designate someone to act as your representative in the review procedure.

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 request, 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.
- If you are submitting a grievance about a cancellation of coverage for Client's non-payment of premiums, the grievance will be treated as an expedited grievance.

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 request.
- 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 request..
- Within a reasonable period of time, but not later than 30 days after MHN's receipt of the appeal of a Post-Service request..

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 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 [1-800-728-9899]. 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 request and 30 days after receipt for Post-Service request. 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 [1-800-728-9899] or by sending a written request to:

MHN
Appeals Unit
PO Box 10697
San Rafael, CA 94912

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 duties, obligations or responsibilities of MHN, your employer or group, or you under the terms and conditions of your Plan or 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 or otherwise have a court hear 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, #1520
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, the Member may request that MHN assume all or a portion of a Member's share of the fees and expenses of the arbitration and MHN may do so at its sole discretion. Upon written notice by the Member requesting a hardship application, MHN will forward the request to an independent professional dispute resolution organization for an assessment of the basis of the hardship request. 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 certain types of 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, 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

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 [1-800-728-9899], or write to:

MHN
Quality Management Department
PO Box 10697
San Rafael, CA 94912

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. 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.
6. Members are notified in writing of the resolution of the grievance.
7. 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
PO Box 10697
San Rafael, CA 94912

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 [1-800-728-9899], and use the plan's grievance process before contacting the department. 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 for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhca.gov** has complaint forms, IMR application forms and instructions online.

Second Opinion for Members

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 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. The Practitioner rendering the second opinion will provide a written consultation report to MHN, the Member and the original Participating Practitioner.

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 [**1-800-728-9899**].

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
- Substance Use Disorder, 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 [1-800-728-9899]. 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 [1-800-728-9899]. 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 Disorder, 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 **[1-800-728-9899]**.

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. 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 may use financial incentives when paying Participating Providers. You may request more information about our payment methods by contacting the Customer Contact Center at the telephone number on your MHN ID card.

Reimbursement and Claims Information

You do not need to complete claim forms. Just pay your Copayment, Coinsurance or Deductible, as applicable, directly to your Participating Provider.

Prepayment Fees

Your Employer or Group is responsible for paying Prepayment Fees in full and on time as well as 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.

Note: 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 and Limitations of Benefits

This section details the services, treatments and supplies MHN will not cover. Also, services, treatment, or supplies that are otherwise excluded from coverage in this Evidence of Coverage or exceed the limitations in this Evidence of Coverage will not be covered. Please read these Exclusions carefully before seeking any counseling or treatment through MHN.

MHN administers Behavioral Healthcare Services in accordance with the Benefit Chart outlined in the back section of this booklet. MHN will not cover services which are not Medically Necessary Services (See Definitions Section). MHN will cover only those Behavioral Health Services which are:

- Delivered by Participating Providers who are acting within the scope of their license, if any is required under California law.
- Except in the event of Emergency Services and Care, pursuant to treatment plans, of Participating Practitioners that prescribe Covered Services for diagnosed Mental Health Disorders or Substance Use Disorders and
- Which treatment plans are developed by a Practitioner who is qualified and licensed to provide Covered Services. (Please see the Section entitled “Emergency Care”) and
- Where Behavioral Health Treatment for Pervasive Developmental Disorder or Autism
- is required by a Treatment Plan certain additional requirements apply as set forth in the “Definitions” section below, under Behavioral Health Treatment for Pervasive Developmental Disorder or Autism

In addition, the following services are not covered by MHN:

- Services in excess of those with respect to which Authorization by MHN is obtained.
- All prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a Practitioner in connection with treatment and/or screening for a Mental Health Disorder.
- 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.
- 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 Pre-Authorization from MHN is obtained.
- Ancillary services such as:
 - Vocational rehabilitation within a treatment plan designed exclusively for the purpose of attaining skills needed to obtain or retain employment.
 - Speech or occupational therapy.
 - Sleep therapy, however Medically Necessary treatment of sleep disorders, which are related to or comprise a Mental Health Disorder are covered.
 - Nutrition services, except as otherwise required by law.

- Custodial Services for services and supplies that are intended to help a Member meet their personal, non-medical or non-behavioral health needs. This exclusion does not apply to Medically Necessary Covered Services provided to a Member residing in a custodial care facility.

- Educational skills

No coverage for services if the purpose of the services is to gain academic knowledge for educational advancement in order to help students to achieve passing marks and advance from grade to grade. For example, MHN does not cover:

- (1) Tutoring
- (2) Special education or instruction that is required and designed to assist a handicapped child to make academic progress.
- (3) Academic coaching

This exclusion does not apply to “health education,” and medically necessary basic health care (behavioral) testing and treatment for pervasive developmental disorders or Autism.

- Employment skills

No coverage for services within a treatment plan designed exclusively for employment counseling or training, investigations required for employment, education for obtaining or maintaining employment or for professional certification or vocational rehabilitation, or education for personal or professional growth.

- Social skills

No coverage for teaching manners or etiquette.

- Psychological testing except as conducted by a Practitioner, acting within the course and scope of his license, for assistance in treatment planning, including medication management or diagnostic clarification and specifically excluding psychological testing related to medical conditions that are not Mental Health Disorders or to determine surgical readiness. Also excluded is coverage for scoring of automated computer based reports, unless the scoring is performed by a provider qualified to perform it.
- Services to repair or replace or the replacement of supplies incident to damage to a hospital or facility caused by the Member but are not due to the Member’s medical or mental condition.
- Healthcare services, treatment or supplies determined to be Experimental by MHN in accordance with accepted mental health standards, except as otherwise required by law. (Please see section entitled “Independent Medical Review”)
- Biofeedback treatment or hypnotherapy, unless preauthorized by the Plan based upon Medical Necessity.
- Acupuncture
- 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 that is not for the treatment of a Mental Health Disorder or Substance Use 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 preauthorized by MHN based upon Medical Necessity.

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.

In the event of Group’s non-payment of Prepayment Fees when due, then MHN will mail the Employer or Group a notice of cancellation 30 days before any cancellation of coverage (“Grace Period”). This notice of cancellation will provide the Employer or Group information regarding the consequences of the Employer or Group’s failure to pay the Prepayment Fees within 30 days of the date the notice of cancellation was mailed. Such cancellation will not be effective until the day the notice of start of Grace Period is dated and coverage will remain uninterrupted before the expiration of the Grace Period. Such cancellation shall not be mailed until the last date of paid coverage and the cancellation shall not be effective until the expiration of the Grace Period.

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 thirty (30) days of the date of notice of cancellation.

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

The Plan may cancel a Member's coverage where the Plan demonstrates that the Member has performed an act or practice constituting fraud or has made an intentional misrepresentation of material fact, as prohibited by the terms of coverage. However, after 24 months following a Member's coverage under this Agreement, the Plan may not cancel coverage due to any omissions, misrepresentations or inaccuracies contained in the Member's enrollment form or materials whether willful or not. Acts or practices which constitute fraud, subjecting the Member to cancellation under this section include:

Member provided fraudulent or intentionally misrepresented or fraudulently concealed information of material fact;

- The plan demonstrates fraud or an intentional misrepresentation of material fact under the terms of the health care service plan contract by the individual contract holder or employer.
- Obtained or attempted to obtain services or benefits by means of fraud or intentional misrepresentations of a material fact.

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.

MHN will conduct a fair investigation of the facts before any termination for any of the above reasons is carried out.

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. In order for coverage to continue, the first Prepayment Fee paid by you must be, at a minimum, an amount that is sufficient to pay any required premiums that are owed and all premiums amounts that may or may not be past 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 by contacting MHN at **[1-800-728-9899]**. 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 MEDICAL 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 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, and notify you in the event of a breach of your unsecured protected health information. We must follow the terms of this Notice while it is in effect. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your protected health information we already have as well as any of your protected health information we receive in the future. We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in the Notice. This will include, but may not be limited to updating the Notice on our web site. 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, to be reimbursed by another insurer that may be responsible for payment or for premium billing.
- **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.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, 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.** We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you. We can disclose your protected health information to that entity if it has contracted with us to administer your health care program on its behalf.
- **Person(s) Involved in Your Care or Payment for Your Care.** We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who is involved

with your care or payment. We may disclose the relevant protected health information to these persons if you do not object or we can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in your best interest.

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., California Department of Health Services) 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.
- **Fundraising Activities.** We may use or disclose your protected health information for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

Other Uses or Disclosures that Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your protected health information, with limited exceptions, for the following reasons:

- **Marketing.** We will request your written authorization to use or disclose your protected health information for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.
- **Sale of Protected Health Information.** We will request your written authorization before we make any disclosure that is deemed a sale of your protected health information, meaning that we are receiving compensation for disclosing the protected health information in this manner.
- **Psychotherapy Notes** – We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.
- **Other Uses or Disclosures.** All other uses or disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law.
- **Revocation of an Authorization.** 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. If we deny your request for access, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- **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, or change, 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 certain 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. **MHN will not disclose medical information related to sensitive health care services provided to a protected individual to the policyholder, primary subscriber, or any plan enrollees other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.**
- **Right to Receive Confidential Communications.** Protected Individuals have the right to request that We communicate with You about Your PHI at an alternative mailing address, email address or telephone number You designate. MHN permits subscribers and enrollees to request, and shall accommodate requests for, confidential communication in the form and format requested by the individual, if it is readily producible in the requested form and format, or at alternative locations. The confidential communication request shall be valid until the subscriber or enrollee submits a revocation of the request or a new confidential communication request is submitted. The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication. A request for confidential communication shall be implemented by MHN within seven 7 calendar days of the receipt of an electronic transmission or telephonic request or within 14 calendar days of receipt by first-class mail delivered. MHN will acknowledge receipt of the confidential communications request and advise the subscriber or enrollee of the status of implementation of the request if a subscriber or enrollee contacts MHN. For Protected Individuals who have not designated an alternative mailing address, MHN will send the communications to the address or telephone number on file in the name of the Protected Individual.

Please send requests for Confidential Communications to the following address:

MHN NSU
PO Box 10697
San Rafael, CA 94912

Or email to:

AuthorizationDisclosure@healthnet.com.

- **Right to opt-out of mailed accrual (accumulator) notices.** You have the right to opt-out of receiving mailed accrual (accumulator) notices regarding your Deductibles and Out-Of-Pocket Maximums. You can ask to receive those notices electronically instead. You can mail your request directly to: MHN P.O. Box 550 Rancho Cordova, CA 95741-0550.
- **Right to Receive Sensitive Services.** You are not required to obtain the policyholder, primary subscriber, or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive services if you have the right to consent. For protected individuals who have not designated an alternative mailing address, MHN will send the communications to the address or telephone number on file in the name of the protected individual.
- **Right to a Notice in the Event of a Breach.** You have a right to receive a notice of a breach involving your protected health information (PHI) should one occur.
- **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.healthnet.com. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

Privacy 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 U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, (TDD: 1-866-788-4989) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. 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 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:

Address: MHN/Health Net Privacy Office
Attention: Privacy Officer
P.O. Box 9103
Van Nuys, CA 91409

You may also contact us at:

Telephone: 1-800-522-0088
Fax: 1-818-676-8314
Email: Privacy@healthnet.com

Notice of Non-Discrimination

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Managed Health Network (MHN), complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

MHN:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact MHN's Customer Contact Center at 1-888-426-0023 (TDD: 711)

If you believe that MHN has failed to provide these services or discriminated in another way, you can file a grievance by calling the number above and telling them you need help filing a grievance; MHN's Customer Contact Center is available to help you. You can also file a grievance by mail, fax or online at:

MHN Appeals & Grievances
2370 Kerner Blvd
San Rafael, CA 94901

Fax: 1-415-257-1454

Online: www.mhn.com

If you are not satisfied with the decision or it has been more than 30 days since you filed the complaint, you may submit an [Independent Medical Review Application/Complaint Form](#) to the Department of Managed Health Care (DMHC). The form is available at [IMR Application/Complaint Form](#).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697) if there is a concern of discrimination based on race, color, national origin, age, disability, or sex..

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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 Disorder 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 Health 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: Those services determined by MHN to be Medically Necessary for the treatment of Mental Health Disorder or Substance Use Disorder health benefits determined by MHN to be Covered Services under this Plan.

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism: Behavioral health treatment includes Inpatient and Outpatient professional and facility services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a Member diagnosed with pervasive developmental disorder or autism.

- The treatment must be prescribed by a licensed Physician and surgeon, or developed by a licensed psychologist, and must be provided under a documented Treatment Plan prescribed, developed and approved by a Qualified Autism Service Provider providing treatment to the Member for whom the treatment plan is developed. The treatment must be administered by one of the following:
 - Qualified Autism Service Provider;
 - A qualified autism service professional supervised by the qualified autism service provider.

- A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.
- A Provider, who is a licensed physician or licensed psychologist, must establish the diagnosis of pervasive developmental disorder or autism. In addition, the Qualified Autism Service Provider must submit the initial Treatment Plan to MHN.
- The Treatment Plan must have measurable goals over a specific timeline, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The Treatment Plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.
- The Qualified Autism Service Provider must submit updated Treatment Plans to MHN for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no more than six-months thereafter. The updated treatment plan must utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
- The Qualified Autism Service Provider may discontinue intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

Benefits: Behavioral Healthcare Services that are covered by Client’s Plan as further set forth in the Appendix labeled “Benefits Chart” section of this booklet.

Combined Evidence of Coverage and Disclosure Form: A document issued by MHN or another licensed health plan or insurer to a Member that describes a summary description of 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 certain Covered Services, excluding permitted Deductibles, if any.

Covered Services: Substance Use Disorder or Mental Healthcare Services which constitute the Benefits that are covered under this Plan. Coverage for preventive services as required by Federal Health Care Reform (PPACA § 1001 and PHSA § 2713), and as described in the Benefits Chart Appendix to this Evidence of Coverage, will be limited to screening and appropriate referral. No other preventive services are covered by this Plan. The determination of whether a service meets the criteria of a Covered Service as provided for by the Plan 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.

Dependent: Any person who is the legal spouse of a Subscriber, or a child of a Subscriber or Subscriber's spouse, who otherwise meets the eligibility requirements established 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. You will be notified by us of your Deductible accumulation for each month in which benefits were used. You can also obtain an update on your Deductible accumulation by calling the Customer Contact Center at the telephone number on your ID card.

Diagnostic and Statistical Manual of Mental Disorders (DSM): A listing of diagnostic categories and criteria which provides guidelines for making diagnoses of Mental Health Disorders. The DSM is a widely accepted basis for describing the presence and type of these disorders. A DSM diagnosis of Mental Health 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 claim for Behavioral Healthcare Services presented for payment as a Covered Service under Client's Plan that is denied, modified, or delayed by a decision of the Plan in whole or in part due to a finding that the service is not Medically Necessary, not a Covered Service and/or that the service was provided to a non-Covered Person.

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 for Substance Use Disorder. 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 determined by Plan to be an investigatory or an unproven procedure or treatment regimen based on a failure to 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 Behavioral Healthcare Services, including Inpatient, residential, day treatment, partial hospitalization or Outpatient care for the diagnosis and/or treatment of Substance Use Disorder and/or Mental Health 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 Health 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"): means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of Mental Health and Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

For these purposes:

- “Generally accepted standards of Mental Health and Substance Use Disorder care” means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health and Substance Use Disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.
- “Health care provider” means any of the following:
 - A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
 - An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
 - A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.
 - An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
 - An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
 - A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
 - A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
 - A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

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 Health Disorder: A Mental Health 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 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 Health Disorder, including **Behavioral Health Treatment for Pervasive Developmental Disorder or Autism**, as defined above

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: The most you could have to pay per year for covered services. This includes any deductible, coinsurance or copayment amounts. You will be notified by us of your Out-Of-Pocket Maximum accumulation for each month in which benefits were used. You can also obtain an update on your Out-Of-Pocket Maximum accumulation by calling the Customer Contact Center at the telephone number on your ID card.

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, or Qualified Autism Service Provider or qualified autism service professional who is duly licensed or certified under the laws of the California. Practitioner also includes qualified autism paraprofessionals who are not licensed, as required by California law and are described in the Definitions sections of this EOC (See "Qualified Autism Service Provider")

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 an Employer or Group or Subscriber, as applicable, for the Covered Services for each Member who is enrolled with MHN pursuant to the Agreement.

Protected Individual: Any adult subscriber or enrollee covered under a health plan or health insurance policy or a minor subscriber or enrollee who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law. Protected Individual does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code.

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.

Qualified Autism Service Provider means either of the following: (1) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified. (2) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers employ and supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider and implement

services for pervasive developmental disorder or autism pursuant to the treatment plan developed and approved by the Qualified Autism Service Provider.

- A qualified autism service professional is a behavioral service provider who meets the education and experience qualifications described in CA Health and Safety Code, Division 2, Chapter 2.2, Article 5.6, Section 1374.73 for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program and is employed by a qualified autism service provider or an entity or group that employs qualified autism service providers.
- A qualified autism service paraprofessional is an unlicensed and uncertified individual supervised by a qualified autism service provider or qualified autism service professional, who provides treatment and implements services pursuant to a treatment plan, developed and approved by a qualified autism service provider and has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that employs qualified autism service provider or is employed by a qualified autism service provider or an entity or group that employs qualified autism service providers and who meets the education and training qualifications described in CA Health and Safety Code, Division 2, Chapter 2.2, Article 5.6, Section 1374.73.

Sensitive Services: All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929 and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

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 who meets the eligibility requirements established by the Employer or Group and for whom a Prepayment Fee is paid in full to MHN by Group, Employer or Subscriber as applicable.

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

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 Mira Costa College

Who Is Eligible For Benefits?

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

As an active employee you are eligible to participate in the Plan. Additionally, your spouse and children up to age twenty-six (26) regardless of whether the adult child is a tax dependent, student, resides with or received financial support from the parent are eligible. Children of any age who are incapable of self-sustaining employment due to mental or physical handicap are also eligible.

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 [1-800-728-9899]. 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			
GROUP NAME:	MiraCosta College	ORIGINAL EFFECTIVE DATE:	1/1/2021
ACCOUNT #:	2888	BENEFIT REVISION DATE:	6/1/2021
PLAN CODE:	OM6	MHPAEA COMPLIANT:	YES
PLAN TYPE:	HMO	GRANDFATHERED:	NO
BENEFIT SCHEDULE:	CALENDAR	CDA APPLIES:	NO
PRODUCT RISK TYPE:	MC RISK	CDA ID Code:	N/A
PLAN NAME:	MiraCosta College		
MANAGED CARE BENEFITS			
Deductible (combined for medical and mental health/chemical dependency plan)			IN NETWORK
INN/OON Combined:	NO	For each member	\$0
4 th Quarter carry over:	NO	For each family	\$0
Out-of-Pocket Maximum (combined for medical & mental health/chemical dependency plan)			IN NETWORK
INN/OON Combined:	NO	For each member	\$1500
Includes Deductible:	YES	For each family	\$3,000
Emergency Services in an Emergency Room (mental health/chemical dependency treatment)			IN NETWORK
		Emergency Room Professional	\$35
		Emergency Room Facility 1	\$0
		Ambulance Cost Share	\$0
Laboratory Services (mental health/chemical dependency treatment)			IN NETWORK
		Outpatient Laboratory Services	\$0
Mental Illnesses- OUTPATIENT			IN NETWORK
INN/OON Max Combined:	NO	Outpatient Mental Health Consultation (Includes In Home Visits, Medical Management)	\$20/\$0
MH/SA Combined:	NO	Outpatient Mental Health Group therapy session	\$10/\$0
		Outpatient mental health- Telemedical Services *	\$0
		Maximum Visits	UNLIMITED/\$0
		Applied Behavioral Analysis (ABA)	\$0
		Outpatient Mental Health Other- (includes alternate care; partial hospitalization/Day treatment/ intensive outpatient programs, 23 Hr. Observation, Psychological Testing, Neuropsychological Testing, Transcranial Magnetic Stimulation (TMS).	\$0
Mental Illnesses- INPATIENT			IN NETWORK
INN/OON Max Combined:	NO	Inpatient Care in a Hospital	\$0
MH/SA Combined:	NO	Residential Treatment Centers	\$0
		<i>Maximum Days</i>	UNLIMITED/\$0
		Inpatient Physician Visits (Includes IP ECT Professional)	\$0
Chemical Dependency Rehabilitation & Detoxification - OUTPATIENT			IN NETWORK
INN/OON Max Combined:	NO	Outpatient Chemical Dependency Consultation/ (Includes In Home Visits, Medical Management)	\$20/\$0
MH/SA Combined:	NO	Outpatient Chemical Dependency Group therapy session	\$10/\$0
		Outpatient Chemical Dependency- Telemedical Services	\$0
		<i>Maximum Visits</i>	UNLIMITED/\$0
		Methodone	n/a
		Outpatient Chemical Dependency - Other (includes outpatient detoxification; alternate care; partial hospitalization/day treatment/ intensive outpatient programs, 23 Hr. Observation.	\$0

Chemical Dependency Rehabilitation & Detoxification - INPATIENT		IN NETWORK
INN/OON Max Combined:	NO	Inpatient Care in a Hospital \$0
MH/SA Combined:	NO	Residential Treatment Centers \$0
		Maximum Days UNLIMITED/\$0
		Inpatient Physician Visit[SRB1] \$0
Is Prior Authorization Required?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	IN NETWORK
Pre-Auth Penalty apply:	YES	Inpatient Pre-Auth penalty 100%

* Telehealth (telemedical) coverage mirrors in-person coverage based on the type of service provided.

Prior Auth Notes:

INN:

OON:

Notes Benefits:

IN NETWORK Services

Outpatient:

Inpatient:

Alternate Care:

Methadone:

OUT of NETWORK Services

Outpatient:

Inpatient:

Alternate Care:

Methadone

Deductible Applies to:

INN:

OON:

Deductible Notes:

OOP Max Applies to:

INN:

OON:

OOP Max Notes:

CDA Instruction:

Managed Care Protocols:

English

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or call 1-888-426-0023 (TTY: 711). If you bought coverage through the California marketplace call 1-888-426-0023 (TTY: 711). For more help: If you are enrolled in a PPO or EPO insurance policy from Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in an HMO or HSP plan from Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219.

Arabic

خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية أو اتصل على مركز الاتصال التجاري في 1-888-426-0023 (TTY: 711). في حال قمت بشراء التغطية من سوق كاليفورنيا، اتصل على الرقم 1-888-426-0023 (TTY: 711) وللحصول على المساعدة: في حال كنت مسجلاً في بوليصة تأمين المنظمة المزودة المفضلة PPO أو المنظمة المزودة الحصرية EPO من شركة التأمين على الحياة Health Net Life Insurance Company، اتصل على قسم التأمين في كاليفورنيا على الرقم 1-800-927-4357. في حال كنت مسجلاً في منظمة المحافظة على الصحة HMO أو خطة التوفير الصحية HSP من شركة Health Net of California, Inc.، اتصل على خط المساعدة في قسم الرعاية الصحية المدارة DMHC على الرقم 1-888-HMO-2219.

Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք 1-888-426-0023 (TTY: 711) հեռախոսահամարով: Եթե սպահովագրում եք գնել Կալիֆոռնիայի շուկայական հրապարակի փոփոցով, զանգահարեք 1-888-426-0023 (TTY: 711) հեռախոսահամարով: Լրացուցիչ օգնության համար, եթե անդամագրված եք Health Net Life Insurance Company-ի PPO կամ EPO սպահովագրությանը, զանգահարեք Կալիֆոռնիայի Ապահովագրության բաժին՝ 1-888-927-4357 հեռախոսահամարով: Եթե անդամագրված եք Health Net of California, Inc.-ի HMO կամ HSP ծրագրին, զանգահարեք DMHC օգնության գիծ՝ 1-888-HMO-2219 հեռախոսահամարով:

Chinese

免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 1-888-426-0023 (TTY: 711)。如果您透過加州健康保險交易市場購買承保，請致電 1-888-426-0023 (TTY: 711)。如需進一步協助：如果您透過 Health Net Life Insurance Company 投保 PPO 或 EPO 保單，請致電 1-800-927-4357 與加州保險局聯絡。如果您透過 Health Net of California, Inc. 投保 HMO 或 HSP 計畫，請致電 DMHC 協助專線 1-888-HMO-2219。

Hindi

बिना लागत वाली भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या 1-888-426-0023 (TTY: 711) पर कॉल करें। यदि आपने कैलिफोर्निया मार्केट प्लेस के माध्यम से कवरेज खरीदा है तो 1-888-426-0023 (TTY: 711) पर कॉल करें। अधिक मदद के लिए: यदि आप Health Net Life Insurance Company पीपीओ PPO या ईपीओ EPO बीमा पॉलिसी में नामांकित हैं, तो कैलिफोर्निया बीमा विभाग को 1-800-927-4357 पर कॉल करें। यदि आप Health Net of California, Inc. के एचएमओ HMO या एचएसपी HSP प्लैन में नामांकित हैं, तो डीएमएचसी DMHC हेल्पलाइन के 1-888-HMO-2219 पर कॉल करें।

Hmong

Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Kev pab, hu rau pab ntawm tus xov tooj teev nyob rau hauv koj daim ID card los yog hu rau 1-888-426-0023 (TTY: 711). Yog tias koj yuav kev pov hwm ntawm California marketplace hu 1-888-426-0023 (TTY: 711). Xav tau kev pab ntxiv: Yog koj tau tsab ntawv tuav pov hwm PPO los yog EPO los ntawm Health Net Life Insurance Company, hu mus rau CA Dept. of Insurance ntawm 1-800-927-4357. Yog koj tau txoj kev pab kho mob HMO los yog HSP los ntawm Health Net of California, Inc., hu mus rau DMHC tus xov tooj pab Helpline ntawm 1-888-HMO-2219.

Japanese

無料の言語サービス。通訳をご利用いただけます。日本語で文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、1-888-426-0023、(TTY: 711)までお電話ください。カリフォルニア州のマーケットプレイス（保険購入サイト）を通じて保険を購入された方は、1-888-426-0023 (TTY: 711) までお電話ください。さらに援助が必要な場合:Health Net Life Insurance CompanyのPPOまたはEPO保険ポリシーに加入されている方は、カリフォルニア州保険局 1-800-927-4357 まで電話でお問い合わせください。Health Net of California, Inc.のHMOまたはHSPに加入されている方は、DMHCヘルプライン 1-888-HMO-2219 まで電話でお問い合わせください。

Khmer

សេវាកាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មនៃក្រុមហ៊ុន 1-888-426-0023 (TTY: 711)។ បើសិនអ្នកបានទិញការធានារ៉ាប់រងតាមរយៈ ទីផ្សារនៃរដ្ឋកាលីហ្វ័រញ៉ា សូមទូរសព្ទទៅលេខ 1-888-926-4988 (TTY: 711)។ សម្រាប់ជំនួយបន្ថែម ៖ បើសិនអ្នកបានចុះឈ្មោះក្នុងគោលការណ៍ធានារ៉ាប់រង PPO ឬ EPO ពីក្រុមហ៊ុនធានារ៉ាប់រងជីវិត Health Net Life Insurance Company សូមទាក់ទងទៅនាយកដ្ឋានធានារ៉ាប់រង CA តាមរយៈទូរសព្ទលេខ 1-800-927-4357។ បើសិនអ្នកបានចុះឈ្មោះក្នុងផែនការ HMO ឬ HSP ពីក្រុមហ៊ុន Health Net of California, Inc. នៃរដ្ឋកាលីហ្វ័រញ៉ា សូមទាក់ទងលេខទូរសព្ទជំនួយ DMHC ៖ 1-888-HMO-2219។

Korean

무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하시거나 1-888-426-0023 (TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스를 통해 보험을 구입하셨으면 1-888-426-0023 (TTY: 711) 번으로 전화해 주십시오. 추가 도움이 필요하시면, Health Net Life Insurance Company의 PPO 또는 EPO 보험에 가입되어 있으시면 캘리포니아 주 보험국에 1-800-927-4357번으로 전화해 주십시오. Health Net of California, Inc.의 HMO 또는 HSP 플랜에 가입되어 있으시면 DMHC 도움라인에 1-888-HMO-2219번으로 전화해 주십시오.

Navajo

Saad Bee Áká E'eyeed T'áá Jiik'e. Ata' halne'igii hólo. T'áá hó hazaad k'ehji naaltsoos hach'í wóltah. Shiká a'doowof ninizingo naaltsoos bee néiho'dólzínigii bikáa'gi béesh bee hane'í bikáá' áajl' hodiilnih éi doodall' 1-888-426-0023 (TTY: 711). California marketplace hoolyéhíjí béeso ách'áááh naanilí ats'iis baa áháyá biniyé nahiniil'go éi kojí' hólné' 1-888-426-0023 (TTY: 711). Shiká anáa'doowof jnizingo: PPO éi doodall' EPOjí Health Net Life Insurance Company wolyéhíjí béeso ách'áááh naa'níil biniyé hwe'ítina' bik'é'éstí'go éi CA Dept. of Insurance bich'í' hojilnih 1-800-927-4357. HMO éi doodall' HSPjí Health Net of California, Inc.ójí béeso ách'áááh naa'níil biniyé hats'iis bik'é'éstí'go éi kojí' hojilnih DMHC Helpline 1-888-HMO-2219.

Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید یا با مرکز تماس بازرگانی 1-888-426-0023 (TTY: 711) تماس بگیرید. اگر پوشش بیمه را از طریق بازارگاه کالیفرنیا خریداری کردید با شماره 1-888-426-0023 (TTY: 711) تماس بگیرید. برای دریافت راهنمایی بیشتر: اگر در بیمه نامه PPO یا EPO از سوی Health Net Life Insurance Company عضویت دارید، با CA Dept. of Insurance به شماره 1-800-927-4357 تماس بگیرید. اگر در برنامه HMO یا HSP از سوی Health Net of California, Inc. عضویت دارید، با خط راهنمایی تلفنی DMHC به شماره 1-888-HMO-2219 تماس بگیرید.

Panjabi (Punjabi)

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਤੋਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਬਾਸਿਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਿਰਪਾ ਕਰਕੇ 1-888-426-0023 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕੈਲੀਫੋਰਨੀਆਂ ਮਾਰਕਿਟ ਪਲੇਸ ਦੇ ਰਾਹੀਂ ਬੀਮਾ ਕਵਰੇਜ਼ ਖਰੀਦੀ ਹੋ ਤਾਂ 1-888-426-0023 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਧੇਰੀ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਪੀਪੀਓ PPO ਜਾਂ ਈਓਪੇ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ, ਤਾਂ ਕੈਲੀਫੋਰਨੀਆਂ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਤੋਂ ਇੱਕ ਐਚਐਮਓ HMO ਜਾਂ ਐਚਐਸਪੀ HSP ਪਲੇਨ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ ਤਾਂ ਡੀਐਮਐਚਸੀ DMHC ਹੇਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Кроме того, вы можете позвонить в 1-888-426-0023 (TTY: 711). Если свою страховку вы приобрели на едином сайте по продаже медицинских страховок в штате Калифорния, звоните по телефону 1-888-426-0023 (TTY: 711). Дополнительная помощь: Если вы включены в полис PPO или EPO от страховой компании Health Net Life Insurance Company, звоните в Департамент страхования штата Калифорния (CA Dept. of Insurance), телефон 1-800-927-4357. Если вы включены в план HMO или HSP от страховой компании Health Net of California, Inc., звоните по контактной линии Департамента управляемого медицинского обслуживания DMHC, телефон 1-888-HMO-2219.

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el Centro de Comunicación Comercial de Health Net, al 1-888-426-0023 (TTY: 711). Si adquirió la cobertura a través del mercado de California, llame al 1-888-426-0023 (TTY: 711). Para obtener más ayuda, haga lo siguiente: Si está inscrito en una póliza de seguro PPO o EPO de Health Net Life Insurance Company, llame al Departamento de Seguros de California, al 1-800-927-4357. Si está inscrito en un plan HMO o HSP de Health Net of California, Inc., llame a la línea de ayuda del Departamento de Atención Médica Administrada, al 1-888-HMO-2219.

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card o tawagan ang 1-888-426-0023 (TTY: 711). Kung bumili kayo ng pagsakop sa pamamagitan ng California marketplace tawagan ang 1-888-426-0023 (TTY: 711). Para sa higit pang tulong: Kung nakatala kayo sa insurance policy ng PPO o EPO mula sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung nakatala kayo sa HMO o HSP na plan mula sa Health Net of California, Inc., tawagan ang Helpline ng DMHC sa 1-888-HMO-2219.

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้สามได้ คุณสามารถให้ขานเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตาม หมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ โทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-888-426-0023 (TTY: 711) หากคุณ ซื้อความคุ้มครองผ่านทาง California marketplace โทร 1-888-426-0023 (TTY: 711) สำหรับความช่วยเหลือเพิ่มเติม หาก คุณสมัครทำกรมธรรม์ประกันภัย PPO หรือ EPO กับ Health Net Life Insurance Company โทรหากรมการประกันภัยรัฐ แคลิฟอร์เนียได้ที่ 1-800-927-4357 หากคุณสมัครแผน HMO หรือ HSP กับ Health Net of California, Inc. โทรหาสายด่วน ความช่วยเหลือของ DMHC ได้ที่ 1-888-HMO-2219.

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi 1-888-426-0023 (TTY: 711). Nếu quý vị mua khoản bảo trả thông qua thị trường California 1-888-426-0023 (TTY: 711). Để nhận thêm trợ giúp: Nếu quý vị đăng ký hợp đồng bảo hiểm PPO hoặc EPO từ Health Net Life Insurance Company, vui lòng gọi Sở Y Tế CA theo số 1-800-927-4357. Nếu quý vị đăng ký vào chương trình HMO hoặc HSP từ Health Net of California, Inc., vui lòng gọi Đường Dây Trợ Giúp DMHC theo số 1-888-HMO-2219.