



CALIFORNIA

Supplement to the Combined Evidence of Coverage and Disclosure Form
SMI/Individual Plan

CALIFORNIA



SMI/INDIVIDUAL PBHC SCHEDULE OF BENEFITS

Preauthorization is required for all Mental Health Services, including Severe Mental Illness (SMI) Benefits. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through PacifiCare Behavioral Health of California (PBHC), an affiliate of PacifiCare that specializes in mental health. PBHC is available to you toll-free, 24 hours a day, 7 days a week, at 1-800-999-9585.

Severe Mental Illness Benefits³

Inpatient Residential and Day Treatment <i>Unlimited days</i>	Same as medical plan hospitalization Copayment ¹
Outpatient Treatment <i>Unlimited Visits</i>	Same as medical plan office visit Copayment
Emergency and Urgently Needed Services ²	Same as medical plan Emergency and Urgently Needed Services ² Copayment waived if admitted as an inpatient

¹Each Hospital Admission may require an additional Copayment. Please refer to your PacifiCare of California Medical Plan *Schedule of Benefits*.

²Emergency and Urgently Needed Services are Medically Necessary services to prevent serious deterioration of a Member's health resulting from an unforeseen illness or injury manifesting itself by acute symptoms of sufficient severity, including severe pain, such that treatment cannot be delayed.

³Severe Mental Illness diagnoses include: Anorexia Nervosa; Bipolar Disorder; Bulimia Nervosa; Major Depressive Disorder; Obsessive-Compulsive Disorder; Panic Disorder; Pervasive Developmental Disorder, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism; Schizoaffective Disorder; Schizophrenia. In addition, the Severe Mental Illness Benefit includes coverage of Serious Emotional Disturbance of Children (SED).

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WELCOME TO PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA

THIS IS A SUPPLEMENT TO THE PACIFICARE OF CALIFORNIA MEDICAL COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Your PacifiCare of California Medical Plan includes Mental Disorder coverage through PacifiCare Behavioral Health of California (PBHC). This coverage includes the treatment of Severe Mental Illness (SMI) for adults and children and treatment for children with Serious Emotional Disturbance (SED). As a PBHC Member, you and your eligible Dependent always have direct, around-the-clock access to behavioral health benefits. You do not need to go through a Primary Care Physician (PCP) to access your behavioral health benefits, and all services are completely confidential.

This *Combined Evidence of Coverage and Disclosure Form* will help you become more familiar with your Behavioral Health Care benefits. This *Combined Evidence of Coverage and Disclosure Form* should be used in conjunction with your *PacifiCare of California Combined Evidence of Coverage and Disclosure Form*. It is a legal document that explains your Behavioral Health Plan and should answers many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see **Section Seven – Definitions**.

Whether you are the Subscriber of this coverage or enrolled as a Family Member, your *Combined Evidence of Coverage and Disclosure Form* is a key to making the most of your membership, and it should be read completely and carefully. All applicants have a right to view this document prior to enrollment. Individuals with special behavioral health needs should carefully read those sections that apply to them.

Introduction



What else should I read to understand my benefits?

Along with this *Combined Evidence of Coverage and Disclosure Form*, be sure to review your PBHC *Schedule of Benefits* in this *Combined Evidence of Coverage and Disclosure Form* and your *PacifiCare of California Medical Schedule of Benefits* for details of your particular Behavioral Health Plan, including any Co-payments or coinsurance that you may have to pay when accessing Behavioral Health Services. Together, these documents explain your coverage.

What if I still need help?

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

You may write to PBHC at the following address:

PacifiCare Behavioral Health of California, Inc.
3120 West Lake Center Drive
Santa Ana, CA 92704-6917

Or visit the PBHC's Web site: www.pbhi.com



Section One – Understanding Behavioral Health: Your Benefits

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

This Section helps you understand what behavioral health services are and provides a general understanding of some of the services PacificCare Behavioral Health of California provides.

What are Behavioral Health Services?

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

- Mental Disorders, including treatment for the Severe Mental Illness of an adult or child and/or the Serious Emotional Disturbance of a Child.

What is a Severe Mental Illness?

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

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

What is the Serious Emotional Disturbance of a Child?

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

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

What does PacificCare Behavioral Health of California do?

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

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

Section One – Understanding Behavioral Health: Your Benefits



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

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



Section Two – Getting Started: Your Participating Provider

- *Do I need a referral?*
- *How do I access Behavioral Health Services?*
- *Choice of Physicians and Providers*
- *Continuity of Care*

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

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

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

How do I access Behavioral Health Services?

Step 1

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

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

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

Step 2

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

Step 3

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

Choice of Physicians and Providers

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

Call the PBHC Customer Service Department for:

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

Facilities

Along with listing our Participating Providers, your PBHC Participating Provider Directory has detailed information about our Participating Providers. This includes a QUALITY INDEX® for helping you become familiar with our Participating Providers. If you need a copy or would like assistance picking your Participating Provider, please call our Customer Service Department. You can also find an online version of the PBHC Participating Provider Directory at www.pbhi.com.

What if I want to change my Participating Provider?

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

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

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

Can I call PBHC in the evening or on weekends?

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

Section Two – Getting Started: Your Participating Provider



Continuity of Care With a Terminated Provider

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

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

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

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

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

All Continuity of Care requests will be reviewed on a case-by-case basis. Reasonable consideration will be given to the severity of the Member's condition and the

potential clinical effect of a change in Provider regarding the Member's treatment and outcome of the condition under treatment.

If you are receiving treatment for any of the specified Continuity of Care Conditions as limited and described in **Section Seven – Definitions**, and believe you qualify for continued care with the terminating Provider, please call the Customer Service Department and request the form "Request for Continuity of Care." Complete and return the form to PBHC as soon as possible, but within thirty (30) calendar days of the Provider effective date of termination.

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

Continuity of Care for New Members

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

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

Behavioral Health Services provided by a Non-Participating Provider may be covered by PBHC for the purpose of safely transitioning you or your Dependent to a PBHC Participating Provider. If the Behavioral Health Services are preauthorized by PBHC, PBHC may cover such services to the extent they would be covered if provided by a PBHC Participating Provider under the PBHC Behavioral Health Plan. This means that you will only be responsible for your Copayment or coinsurance listed on the *Schedule of Benefits* and any services received will count toward your PBHC benefit plan



Section Two – Getting Started: Your Participating Provider

limits. The Non-Participating Provider must agree in writing to the same contractual terms and conditions that are imposed upon PBHC Participating Providers, including reimbursement methodologies and rates of payment.

All services, except for Emergency Services, must be approved by PBHC. If you would like to request continuing treatment from a Non-Participating Provider, call the PBHC Customer Service Department within 30 days of your effective with PBHC, or as soon as reasonably possible, prior to your effective date of coverage under the PBHC Behavioral Health Plan. If you have any questions or would like a copy of PBHC's continuity-of-care policy, call or write the PBHC Customer Service Department.

Outpatient Treatment

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

Section Three – Emergency Services and Urgently Needed Services



- *What is an Emergency?*
- *What are Psychiatric Emergency Services?*
- *What To Do When You Require Psychiatric Emergency Services*
- *What To Do When You Require Urgently Needed Services*
- *Continuing or Follow-Up of Emergency Treatment*
- *If I am out of State or traveling, am I still covered?*

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

IMPORTANT!

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

What is an Emergency?

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

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

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

What are Psychiatric Emergency Services?

Psychiatric Emergency Services are Medically Necessary ambulance or ambulance transport services provided through the 911 Emergency response system. It includes the medical screening, examination and evaluation by a Physician, or other licensed personnel – to the extent provided by law – to determine if a

Psychiatric Emergency exists. If a Psychiatric Emergency condition exists, Psychiatric Emergency Services include the care and treatment by a Physician necessary to stabilize or eliminate the Emergency condition within the capabilities of the facility.

What To Do When You Require Psychiatric Emergency Services

Step 1: In an Emergency, get help or treatment immediately.

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

Step 2: Then, within 48 hours of your Emergency, or as soon as is reasonably possible after your condition is stable, you, or someone acting on your behalf, must call PBHC at 1-800-999-9585.

This is important.

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

Step 3: PBHC will arrange follow up services for your condition after an Emergency. PBHC may move you to a Participating Provider in our network, as long as the move would not harm your health.

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

What To Do When You Require Urgently Needed Services

In-Area Urgently Needed Services

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



Section Three – Emergency Services and Urgently Needed Services

from a licensed behavioral health professional wherever you are located.

Out-of-Area Urgently Needed Services

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

When you are temporarily outside the geographic area served by your Participating Provider, and you believe that you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your Participating Provider. If you are calling during nonbusiness hours, and your Provider is not immediately available, call PBHC Customer Service Department for assistance in finding a Provider near your area. If your Participating Provider or PBHC is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a licensed behavioral health professional wherever you are located.

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

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

Continuing or Follow-up of Emergency Treatment or Urgently Needed Services

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

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

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

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

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

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

Section Four – Covered Behavioral Health Services



- **What Behavioral Health Services are covered?**
- **Exclusions and Limitations**

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

What Behavioral Health Services are covered?

Behavioral Health Services are covered only when they are:

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

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

I. Mental Health Services for the diagnosis and treatment of SMI and SED conditions:

A. Inpatient

1. **Inpatient Mental Health Services** provided at an Inpatient Treatment Center or Day Treatment Center are covered when Medically Necessary, preauthorized by PBHC, and provided at a Participating Facility.
2. **Inpatient Physician Care** – Medically Necessary Mental Health Services provided by a Participating Practitioner while the Member is hospitalized as an inpatient at an Inpatient Treatment Center or is receiving services at a Participating Day Treatment Center and which have been preauthorized by PBHC.

B. Outpatient

1. **Outpatient Physician Care** – Medically Necessary Mental Health Services provided by a Participating Practitioner and preauthorized by

PBHC. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.

II. Other Behavioral Health Services

1. **Ambulance** – Use of an ambulance (land or air) for Emergencies, including, but not limited to, ambulance or ambulance transport services provided through the 911 Emergency response system is covered without prior authorization when the Member reasonably believes that the behavioral health condition requires Emergency Services that require ambulance transport services. Use of an ambulance for a non-Emergency is covered only when specifically authorized by PBHC.
2. **Laboratory Services** – Diagnostic and therapeutic laboratory services are covered when ordered by a Participating Practitioner in connection with the Medically Necessary diagnosis and treatment of a Mental Disorder when preauthorized by PBHC.
3. **Inpatient Prescription Drugs** – Inpatient prescription drugs are covered only when prescribed by a PBHC Participating Practitioner for treatment of a Mental Disorder while the Member is confined to an Inpatient Treatment Center.
4. **Injectable Psychotropic Medications** – Injectable psychotropic medications are covered if prescribed by a PBHC Participating Practitioner for treatment of a Mental Disorder when preauthorized by PBHC.
5. **Psychological Testing** – Medically Necessary psychological testing is covered when preauthorized by PBHC and provided by a Participating Practitioner who has the appropriate training and experience to administer such tests.

Exclusions and Limitations

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

1. Any confinement, treatment, service or supply not authorized by PBHC, except in the event of an Emergency.



Section Four – Covered Behavioral Health Services

2. All services not specifically included in the PBHC *Schedule of Benefits* included with this *Combined Evidence of Coverage and Disclosure Form*.
3. Services received prior to the Member's effective date of coverage, after the time coverage ends, or at any time the Member is ineligible for coverage.
4. Services or treatments which are not Medically Necessary, as determined by PBHC.
5. Services or treatment provided to you which duplicate the benefits to which you are entitled under any applicable workers' compensation laws are not covered.
6. Any services that are provided by a local, state or federal governmental agency are not covered except when coverage under this Behavioral Health Plan is expressly required by federal or state law.
7. Speech therapy, physical therapy and occupational therapy services provided in connection with the treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development.
8. Treatments which do not meet national standards for mental health professional practice.
9. Routine custodial and convalescent care, long-term therapy and/or rehabilitation. (Individuals should be referred to appropriate community resources such as school district or regional center for such services).
10. Any services provided by nonlicensed Providers.
11. Pastoral or spiritual counseling.
12. Dance, poetry, music or art therapy services except as part of a Behavioral Health Treatment Program.
13. School counseling and support services, home-based behavioral management, household management training, peer-support services, recreation, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, wraparound services, Emergency aid to household items and expenses, and services to improve economic stability and interpretation services.
14. Genetic counseling services.
15. Community care facilities that provide 24-hour non-medical residential care.
16. Weight control programs and treatment for addictions to tobacco, nicotine or food.
17. Counseling for adoption, custody, family planning or pregnancy in the absence of a *DSM-IV-TR* diagnosis.
18. Counseling, treatment or services associated with or in preparation for a sex (gender) reassignment operation are not covered.
19. Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence.
20. Personal or comfort items, and non-Medically Necessary private room and/or private-duty nursing during inpatient hospitalization are not covered.
21. With the exception of injectable psychotropic medication as set forth in Section Four, all nonprescription and prescription drugs, which are prescribed during the course of outpatient treatment, are not covered. Outpatient prescription drugs may be covered under your medical plan. Please refer to the Member disclosure materials describing the medical benefit. (Nonprescription and prescription drugs prescribed by a PBHC Participating Practitioner while the Member is confined at an Inpatient Treatment Center and nonprescription and prescription drugs prescribed during the course of inpatient Emergency treatment whether provided by a Participating or Non-Participating Practitioner are covered under the inpatient benefit.)
22. Surgery or acupuncture.
23. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not Medically Necessary.
24. Neurological services and tests, including, but not limited to, EEGs, PET scans, beam scans, MRIs, skull X-rays and lumbar punctures.
25. Treatment sessions by telephone or computer Internet services.
26. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations or career counseling.
27. Educational services to treat developmental disorders, developmental delays or learning disabilities are not covered. A learning disability is a condition where there is a meaningful difference between a child's current academic level of function and the level that would be expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading and psychological and visual integration training as

Section Four – Covered Behavioral Health Services



defined by the *American Academy of Pediatrics Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review*.

28. Treatment of problems that are not Mental Disorders are not covered, except for diagnostic evaluation.

29. Experimental and/or Investigational Therapies, Items and Treatments are not covered, unless required by an external independent review panel as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned “Experimental and Investigational Therapies.” Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by the PBHC Medical Director or a designee. For the purpose of this *Combined Evidence of Coverage and Disclosure Form*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines are met:

- It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA), and such approval has not been granted at the time of its use or proposed use.
- It is a subject of a current investigation of new drug or new device (IND) applications on file with the FDA.
- It is the subject of an ongoing clinical trial (Phase I, II, or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and the Department of Health and Human Services.
- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
- It is being delivered or should be delivered subject to approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
- Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.

- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab test or imaging ordered to evaluate the effectiveness of the Experimental therapy.)
- The source of information to be relied upon by PBHC in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this Behavioral Health Plan, include, but are not limited to the following:
 - The Member’s Medical records;
 - The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
 - Any informed consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
 - The published authoritative medical and scientific literature regarding the drug, device, treatment or procedure;
 - Expert medical opinion;
 - Opinions of other agencies or review organizations (e.g., ECRI Health Technology Assessment Information Services or HAYES New Technology Summaries);
 - Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Healthcare Research and Quality (AHRQ);
 - PBHC Technology Assessment Committee Guidelines.

A Member with a Life-Threatening or Seriously Debilitating condition may be entitled to an expedited external independent review of PBHC’s coverage determination regarding Experimental or Investigational therapies as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned “Experimental and Investigational Therapies”.



Section Four – Covered Behavioral Health Services

30. All exclusions and limitations listed in the PacifiCare of California Group *Subscriber Agreement* and EOC under the “Exclusions and Limitations” section.
31. Methadone maintenance treatment is not covered.
32. Services provided to the Member on an Out-of-Network basis. (SMI and SED coverage is only covered on an In-Network basis under this plan.)

Section Five – Overseeing Your Behavioral Health Services



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

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

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

How PBHC Makes Important Benefit Decisions

Authorization, Modification and Denial of Behavioral Health Services

When a Member requests Mental Health Services, PBHC uses established utilization management (UM) criteria to approve, deny, delay or modify authorization of benefits based on Medical Necessity. The criteria used for evaluating Mental Health Services are based on empirical research and industry standards. These are the *MCAP Behavioral Health Criteria*. The UM criteria used to deny, delay or modify requested services in the Member's specific case will be provided free of charge to the Participating Provider and to the Member. The public is also able to receive specific criteria or guideline, based on a particular diagnosis, upon request.

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

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

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

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

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



Section Five – Overseeing Your Behavioral Health Services

upon in making this decision will be made available upon request by the Member.

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

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

Second Opinions

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

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

- the Member has attempted to follow the plan of care or consulted with the initial Provider concerning serious concerns about the diagnosis or plan of care.

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

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

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

A second opinion will be documented by a consultation report which will be made available to you. If the Provider giving the second opinion recommends a particular treatment, diagnostic test or service covered by PBHC, and it is determined to be Medically Necessary by your Participating Provider, the treatment, diagnostic test or service will be provided or arranged by the Member’s Participating Provider. However, the fact that a Provider furnishing a second opinion recommends a particular treatment, diagnostic test or service does not necessarily mean that the treatment, diagnostic test or service is Medically Necessary or a Covered Service under your PBHC Behavioral Health Plan. You will be responsible for paying any Copayment,

Section Five – Overseeing Your Behavioral Health Services



as set forth in your *Schedule of Benefits*, to the PBHC Provider who renders the second opinion. If you obtain a second opinion without preauthorization from your Participating Provider or PBHC, you will be financially responsible for the cost of the opinion.

If you or your Dependent's request for a second opinion is denied, PBHC will notify you in writing and provide the reason for the denial. You or your Dependent may appeal the denial by following the procedures outlined in the appeals section described below.

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

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

How are new treatment and technologies evaluated?

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

Experimental and Investigational Therapies

PBHC also provides an external independent review process to review its coverage decisions regarding experimental or investigational therapies for PBHC Members who meet all of the following criteria:

1. You have a Life-Threatening or Seriously Debilitating condition, as defined below and it meets the criteria listed in items #2, #3, #4 and #5 below:
 - "Life-threatening" means either or both of the following: (i) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (ii) diseases or conditions with potentially fatal outcomes, where the endpoint of clinical intervention is survival.
 - "Seriously Debilitating" means diseases or conditions that cause major irreversible morbidity.
2. Your PBHC Participating Provider certifies that you have a Life-Threatening or Seriously Debilitating condition, as defined above, for which standard therapies have not been effective in improving your condition, or for which standard therapies would not be medically appropriate for you, or for which there

is no more beneficial standard therapy covered by PBHC than the therapy proposed pursuant to paragraph (3); and

3. Either (a) your PBHC Participating Provider has recommended a treatment, drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, and he or she included a statement of the evidence relied upon by the Participating Provider in certifying his or her recommendation; or (b) you, or your non-Contracting Physician who is a licensed, board-certified or board-eligible Physician or Provider qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from medical and scientific evidence (as defined in California Health and Safety Code Section 1370.4(d)), is likely to be more beneficial for you than any available standard therapy.

Such certification must include a statement of the evidence relied upon by the Physician in certifying his or her recommendation. PBHC is not responsible for the payment of services rendered by non-Contracting Providers that are not otherwise covered under the Member's PBHC benefits; and

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

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

What to do if You Have a Problem

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



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

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

Or at the PBHC Web site: www.pbhi.com

Appealing a Behavioral Health Benefit Decision

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

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

Binding Arbitration and Voluntary Mediation

If the Member is dissatisfied with the appeal, the Member may submit or request that PBHC submit the appeal to voluntary mediation and/or binding arbitration before Judicial Arbitration and Mediation Service (JAMS). Such voluntary mediation or binding arbitration will be limited to claims that are not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

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

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

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

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JAMS. Please contact PBHC for more information on how to obtain a hardship application. The approval or denial of the hardship application will be determined solely by JAMS.

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

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

Expedited Review Process

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

Independent Medical Review of Grievances Involving a Disputed Behavioral Health Service

A Member may request an Independent Medical Review (IMR) of disputed Behavioral Health Services from the Department of Managed Health Care (DMHC) if the Member believes that Behavioral Health Services have

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

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

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

IMR Eligibility for Independent Medical Review: Experimental or Investigational Treatment Decisions

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

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



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

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

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

Disputed Behavioral Health Services Regarding Medical Necessity

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

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

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

Accepted Applications for the Independent Medical Review

Upon receiving a Member's application for IMR, the DMHC will review the request and notify the Member whether the Member's case has been accepted. If the Member's case is eligible for IMR, the dispute will be submitted to an independent medical review

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organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of PBHC, who will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of behavioral health professionals knowledgeable in the treatment of the Member's conditions, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither the Member nor PBHC will control the choice of expert reviews.

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

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

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

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

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

provided, and respond to any requests for additional records or other relevant information from the expert reviewers.

The Independent Medical Review Decision

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

- In the case of a review of Experimental or Investigational determination, if the Member's Provider determines that the proposed treatment or therapy would be significantly less effective if not promptly initiated. In this instance, the analysis and recommendations will be rendered within seven days of the request for expedited review. The review period can be extended up to three days for a delay in providing required documents at the request of the expert.
- If the Behavioral Health Services has not been provided and the Member's Provider or the DMHC certifies in writing that an imminent and serious threat to the Member's life exist, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of the Member's health. In this instance, any analyses and recommendation of the experts must be expedited and rendered within three days of the receipt of the Member's application and supporting information.
- If approved by the DMHC, the deadlines for the expert reviewers' analyses and recommendations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

The IRO will provide the DMHC, PBHC, the Member and the Member's Provider with each of the experts' analyses and recommendations, and a description of the qualifications of each expert. The IRO will keep the names of the expert reviewers confidential, except in cases where the reviewer is called to testify and in response to court orders. In the case of an Experimental or Investigational determination, the experts' analyses will state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial to the Member than any available standard therapy and the reasons for recommending why the therapy should or should not be provided by PBHC,



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citing the Member's specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the expert's recommendation. In the case of a review of the disputed health care service is Medically Necessary and cite the Member's medical condition, the relevant documents in the record and the reviewer's relevant findings.

The recommendation of the majority of the experts on the panel will prevail. If the experts on the panel are evenly divided as to whether the Behavioral Health Services should be provided, the panel's decision will be deemed to be in favor of coverage. If the majority of the experts on the panel does not recommend providing the Behavioral Health Services, PBHC will not be required to provide the service.

When a Decision is Made

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

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

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

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

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

The PBHC Quality Review Process

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

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

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

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

If the Member has submitted a written complaint, the Member will be notified of the completion in writing within thirty (30) days. The oral and written communications involving the Quality Review Process and the results of the review are confidential and cannot be shared with the Member. The outcome of the Quality Review Process cannot be submitted to voluntary mediation or binding arbitration as described above under the PBHC Appeals Process. The Quality Improvement Manager will follow-up to ensure that any corrective actions against a Participating Provider are carried out.

Section Five – Overseeing Your Behavioral Health Services



Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care services plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-999-9585** or **1-888-877-5378 (TDHI)** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal right or remedies that may be available to you. If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatment that are experimental or investigational in nature and payment disputes for Emergency or Urgent medical services. The Department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.



Section Six – General Information

- *What if I get a Bill?*
- *Your Financial Responsibilities*
- *Termination of Benefits*
- *Confidentiality of Information*
- *Translation Assistance*
- *Coverage in Extraordinary Situations*
- *Compensation for Providers*
- *Suspected Health Care Fraud*
- *Public Policy Participation*

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

What if I get a bill?

You should not get a bill from your PBHC Participating Provider because PBHC's Participating Providers have been instructed to send all their bills to us for payment. You may, however, have to pay a Copayment to the Participating Provider each time you receive services. You could get a bill from an emergency room Provider if you use Emergency care. If this happens, send PBHC the original bill or claim as soon as possible and keep a copy for yourself. You are responsible only for the amount of your Copayment, as described in the *Schedule of Benefits* in this *Evidence of Coverage and Disclosure Form*.

Forward the bill to:

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

Your Financial Responsibility

Please refer to the "Payment Responsibility" section of your PacifiCare of California Medical *Combined Evidence of Coverage and Disclosure Form*.

Termination of Benefits

Please refer to the "Termination of Benefits" section of your PacifiCare of California Medical *Combined Evidence of Coverage and Disclosure Form*.

Confidentiality of Information

PBHC takes the subject of Member confidentiality very seriously and takes great measures to protect the confidentiality of all Member information in its possession, including the protection of treatment records and personal information. PBHC provides information only to the professionals delivering your treatment or as otherwise required by law.

Confidentiality is built into the operations of PBHC through a system of control and security that protects both written and computer-based information.

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

Does PBHC offer a translation service?

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

Does PBHC offer hearing and speech-impaired telephone lines?

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

How is my coverage provided under extraordinary circumstances?

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

How does PBHC compensate its Participating Providers?

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

Section Six – General Information



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

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

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

What do you do if you suspect health care fraud?

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

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

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



Section Seven – Definitions

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

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

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

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

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

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

Calendar Year The period of time commencing 12 a.m. on January 1 through 11:59 p.m. on December 31.

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

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

1. An Acute Condition: An acute condition is a behavioral health condition that involves a sudden onset of symptoms due to an illness, or other behavioral health problems that requires prompt medical attention and that has a limited duration. Completion of Covered Services will be provided for the duration of the acute condition.
2. A Serious Chronic Condition: A serious chronic condition is a behavioral health condition due to illness or other behavioral health conditions that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time reasonably necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a Provider, as determined by the PBHC Medical Director (or designee) in consultation with the Member, the terminated Participating Provider and as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed twelve (12) months from the agreement's termination.
3. Other Procedure: Other procedure that has been authorized by PBHC or the Member's assigned Participating Provider as part of a documented course of treatment and had been recommended and documented by the terminated Participating Provider to occur within 180 calendar days of the Agreement's termination date.

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

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

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

Section Seven – Definitions



medication schedules. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Inpatient Treatment Center An acute care Participating Facility which provides Behavioral Health Services in an acute, inpatient setting, pursuant to a written Behavioral Health Treatment Plan approved and monitored by a PBHC Participating Practitioner, and which also:

- provides 24-hour nursing and medical supervision; and
- is licensed, certified, or approved as such by the appropriate state agency.



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

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

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

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

- a. A health intervention for the purpose of treating a Mental Disorder;
- b. The most appropriate level of service or item, considering potential benefits and harms to the Member;
- c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and
- d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. "Cost-effective" does not necessarily mean lowest price.

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

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

- i. *Treating Practitioner* means a Practitioner who has personally evaluated the patient.
- ii. A *health intervention* is an item or service delivered or undertaken primarily to treat (that is, prevent,

diagnosis, detect, treat or palliate) a Mental Disorder or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the Mental Disorder and the patient indications for which it is being applied.

- iii. *Effective* means that the intervention can reasonably be expected to produce the intended result and to have expected benefits that outweigh potential harmful effects.
- iv. *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.
- v. *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the Mental Disorder or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.
- vi. A *new intervention* is one that is not yet in widespread use for the Mental Disorder and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or

Section Seven – Definitions



contradictory, decisions about such new interventions should be based on convincing expert opinion.

vii. An intervention is considered *cost-effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. The application of this criterion is to be on an individual case and the characteristics of the individual patient shall be determinative.

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

Mental Disorder A mental or nervous condition diagnosed by a licensed practitioner according to the criteria in the *DSM-IV-TR* resulting in the impairment of a Member's mental, emotional or behavioral functioning. Mental Disorders include the Severe Mental Illness of a person of any age and the Serious Emotional Disturbance of a Child.

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

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

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

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

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

Participating Providers Participating Practitioners, Participating Preferred Group Practices and Participating Facilities, collectively, each of which has entered into a

written agreement with PBHC to provide Behavioral Health Services to Members.

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

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

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

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

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

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

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

1. Has one or more Mental Disorders as defined by the *Diagnostic and Statistical Manual (DSM-IV-TR)*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms; and
2. Is under the age of eighteen (18) years old.
3. Furthermore, the child must meet one or more of the following criteria:



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- a. As a result of the Mental Disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur: (i) the child is at risk of removal from home or has already been removed from the home; (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
- b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder; or
- c. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

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

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

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

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

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

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

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

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

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

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NOTE: IN ORDER TO FULLY UNDERSTAND YOUR BENEFIT PLAN, THIS PBHC *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM* IS TO BE USED IN CONJUNCTION WITH YOUR PACIFICARE OF CALIFORNIA MEDICAL PLAN *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM*. PLEASE READ BOTH DOCUMENTS CAREFULLY.

PacifiCare Behavioral Health of California, Inc.
3120 West Lake Center Drive
Santa Ana, CA 92704-6917

Customer Service:
1-800-999-9585
1-888-877-5378 (TDHI)
www.pbhi.com



Notes



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Visit our Web site @ www.pacificare.com