Certificate of Coverage

Unimerica Life Insurance Company

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between Unimerica Life Insurance Company and the Group. The *Certificate* describes Covered Behavioral Health Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate,* the Policy includes:

- The *Schedule of Benefits*.
- The Group's *Application*.
- Riders.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. If there are material changes in any of the terms of the Policy, we will provide sixty (60) days advance notice to the Group. The Group shall be responsible for delivering the notice to all Covered Persons and to other persons eligible for coverage.

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

We are delivering the Policy in California. The Policy is governed by ERISA unless the Group is not an employee health and welfare plan as defined by ERISA. To the extent that state law applies, California law governs the Policy.

THIS IS A LIMITED BENEFIT PLAN.

THIS PLAN DOES NOT SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE, HEATH CARE INSURANCE PLANS OR MAJOR MEDICAL EXPENSE INSURANCE.

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

Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to Unimerica Life Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *Certificate* at www.liveandworkwell.com.

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Behavioral Health Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Certificate* and any summaries provided to you by the Group, this *Certificate* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact Us?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

Be Aware the Policy Does Not Pay for All Behavioral Health Services

The Policy does not pay for all behavioral health services. Benefits are limited to Covered Behavioral Health Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Behavioral Health Services.

Decide What Services You Should Receive

Care decisions are between you and your Physician. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the behavioral health professionals who will deliver your care. We arrange for Physicians and other behavioral health professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Behavioral Health Services require prior authorization. In general, Physicians and other behavioral health professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Behavioral Health Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Behavioral Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Co-payment and/or Co-insurance for most Covered Behavioral Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits*.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

Show Your ID Card

You should show your ID card every time you request behavioral health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

When you receive Covered Behavioral Health Services from an out-of-Network provider, you are responsible for requesting payment from us. Please review *Section 5: How to File a Claim* to become familiar with how to request payment from us for Covered Behavioral Health Services you receive from an out-of-Network provider.

Use Your Prior Behavioral Health Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for behavioral health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under the Policy for all other Covered Behavioral Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

Our administrative function regarding whether the Policy will pay for any portion of the cost of a behavioral health service you intend to receive or have received is based on this contract and is subject to the other terms, limitations and exclusions set out in this *Certificate* and *Schedule of Benefits*. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will do the following:

- Pay Benefits according to this Policy and subject to the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

Other persons or entities may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time. In order to receive Benefits, you must cooperate with those service providers.

If you disagree with a determination, you can request an appeal. The complaint and appeals process, including independent review, is described under *Section 6: Questions, Complaints and Appeals*. You may also call the telephone number listed on your identification (ID) card.

Pay for Our Portion of the Cost of Covered Behavioral Health Services

We pay Benefits for Covered Behavioral Health Services as described in *Section 1: Covered Behavioral Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Behavioral Health Services. It also means that not all of the behavioral health services you receive may be paid for (in full or in part) by the Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Behavioral Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Behavioral Health Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources.

- As provided by the medical plan.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at www.liveandworkwell.com.

Certificate of Coverage Table of Contents

Section 1: Covered Behavioral Health Services

When Are Benefits Available for Covered Behavioral Health Services?

Benefits are available only if all of the following are true:

- The behavioral health service is only a Covered Behavioral Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- Covered Behavioral Health Services are received while the Policy is in effect.
- Covered Behavioral Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Behavioral Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a behavioral health condition, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Behavioral Health Service under the Policy.

This section describes Covered Behavioral Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Behavioral Health Services (including any Annual Deductible, Per Occurrence Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Behavioral Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the Allowed Amount you are required to pay in a year (Out-of-Pocket Limit). Allowed amounts for out-of-Network Emergency Health Care Services accrue to the Network Out-of-Pocket Limit.
- Any responsibility you have for notifying us or obtaining pre-authorization.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Emergency Behavioral Health Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Behavioral Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

2. Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction Physician acting within the scope of his or her license.

Benefits for Mental Health Care include Covered Behavioral Health Services for the diagnosis and treatment of Mental Illnesses. Mental Illness is defined as those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded in *Section 2: Exclusions and Limitations*.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- Emergency Behavioral Health Services

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds)

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Medication-assisted treatment for Substance-Related and Addictive Disorders Services.
- Office-based medication-assisted opioid treatment, including methadone.
- Medication-assisted opioid treatment programs, including methadone, provided as part of or separate (stand-alone program) from a facility-based treatment program.
- Treatment programs at federally certified methadone clinics.

Benefits for Covered Behavioral Health Services provided on an outpatient basis are separated into the following two (2) categories in the *Schedule of Benefits* for the purpose of establishing the cost share that applies to the Benefit:

- *Outpatient Office Visits:*
  - Diagnostic evaluations and assessment; treatment planning; treatment and/or procedures; referral services; crisis intervention; medication management; [10]Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorders; medication-assisted opioid treatment, including methadone, separate from a facility-based treatment program; and treatment programs at federally certified methadone clinics.
- *All Other Outpatient Treatment:*
  - Partial Hospitalization/Day Treatment; multidisciplinary intensive outpatient psychiatric treatment; Intensive Outpatient Treatment programs; Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorders; medication-assisted opioid treatment programs, including methadone, provided as part of a facility-based treatment program.

Benefits under this section also include the diagnosis and all Medically Necessary treatment of Severe Mental Illness of a Covered Person of any age and Serious Emotional Disturbances of an Enrolled Dependent child. These Benefits are subject to the Mental Health Care Services and Substance-Related and Addictive Disorders Services cost sharing, including the classification or sub-classification that applies.

Covered Behavioral Health Services provided for Severe Mental Illness of a Covered Person of any age and Serious Emotional Disturbances of an Enrolled Dependent child must meet the definitions of Severe Mental Illness or Serious Emotional Disturbances as defined in this Certificate in *Section 9: Defined Terms*.

Benefits include Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorders under the same terms and conditions that apply to medical conditions. Medically Necessary Behavioral Health Treatment will not be denied or unreasonably delayed:

- Based on an asserted need for cognitive or intelligence quotient (IQ) testing;
- On the grounds that the Behavioral Health Treatment is an Experimental or Investigational Services or educational; or
- On the grounds that Behavioral Health Treatment is not being, will not be, or was not, provided or supervised by a licensed person, entity or group when the provider or supervisor in question is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission of Certifying Agencies.

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

For non-emergency, out-of-Network, inpatient behavioral health care, prior authorization may be required. If so, you must contact the Mental Health/Substance-Related Addictive Disorders Designee for referrals to providers and coordination of care and failure to obtain prior authorization from the designee will result in a penalty. Please refer to the *Mental Health Care and Substance-Related and Addictive Disorders Services* Benefit category in the *Schedule of Benefits* for information on the prior authorization requirements and penalty, if applicable.

For all other levels of care, we encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care, but you are not required to do so and you will not be subject to a penalty if you do not.

If you disagree with a determination, you can request an appeal. The complaint and appeals process, including independent medical review, is described under *Section 6: Questions, Complaints and Appeals*. You can call us at the telephone number on your ID card.

3. Virtual Visits

Virtual visits is distinct from Telehealth services since there are no restrictions on where virtual visit services can originate. Virtual visits covers audio visual visits with a Physician from a designated network and is accessible from any location not limited to home or office or CMS originating site. Unlike Telehealth Services, it requires audio visual medium to facilitate face-to-face interaction for an appropriate evaluation and diagnosis.

Virtual visits for Covered Behavioral Health Services that include the diagnosis and treatment of less serious medical conditions through live audio and video technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of live audio and video technology outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.liveandworkwell com.

Please Note: Not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email,or fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Additional Benefits Required By California Law

4. Telehealth Services

Benefits are available for Covered Behavioral Health Services received through Telehealth. No in-person contact is required between a licensed health care provider and you for Covered Behavioral Health Services appropriately provided through Telehealth, subject to all terms and conditions of the Policy.

Prior to the delivery of Covered Behavioral Health Services via Telehealth, the health care provider at the originating site shall verbally inform you that Telehealth may be used and obtain verbal consent from you for this use. The verbal consent shall be documented in your medical record.

We shall not require the use of Telehealth services when the health care provider has determined that it is not appropriate. The appropriate use of Telehealth services is determined by the treating Physician pursuant to his or her agreement with us.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

To help you find exclusions, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Behavioral Health Services, except as may be specifically provided for in *Section 1: Covered Behavioral Health Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Behavioral Health Service categories described in *Section 1: Covered Behavioral Health Services*, those limits are stated in the corresponding Covered Behavioral Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Behavioral Health Services that fall under more than one Covered Behavioral Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Drugs

1. Prescription drug products of any kind, including prescription drug products for outpatient use that are filled by a prescription order or refill (i.e. a supply of prescription drug products for home/personal use).
2. Over-the-counter drugs and treatments.

B. Experimental or Investigational or Unproven Services

1. Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational Services and Unproven Services are excluded except for Experimental or Investigational Services and Unproven Services as defined under *Section 9: Defined Terms*. The fact that an Experimental or Investigational Service or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorder.

C. Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Behavioral Health Services.*

1. Services performed in connection with conditions not classified as mental disorders in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
3. Tuition for services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act.* This exclusion will not affect or reduce any obligation to provide services for Severe Mental Illness, Serious Emotional Disturbances, pervasive developmental disorder or Autism Spectrum Disorders as required by California law.
4. Transitional Living services.
5. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
6. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
7. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

D. Providers

1. Services performed by a psychiatric provider or other provider who is a family member by birth, adoption or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Except as required by law, services performed by unlicensed providers or which are outside the scope of a provider's licensure. This exclusion does not apply to Covered Behavioral Health Services performed by pastoral counselors.
4. For Benefit plans that do not offer Out-of-Network Benefits, services performed by an out-of-Network provider unless required as Emergency Behavioral Health Services.

E. Services Provided under another Plan

1. Behavioral health services required by law to be provided by a school, municipal, county, state or federal agency or other government agency or for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, school-based services or coverage required by workers' compensation, no-fault auto insurance, or similar legislation.
2. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any behavioral health services that would have been covered under workers' compensation or similar legislation had that coverage been elected.
3. Behavioral Health Services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Behavioral Health Services during active military duty, when you are on active duty for more than 30 days.

F. Travel

1. Behavioral health services provided in a foreign country, unless required as Emergency Behavioral Health Services.
2. Travel or transportation expenses, even though prescribed by a Provider.

G. All Other Exclusions

1. Behavioral Health services and supplies that do not meet the definition of a Covered Behavioral Health Service - see the definition in *Section 9: Defined Terms*.
2. Examinations, testing or treatments that are otherwise covered under the Policy when:
   - Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to get or maintain a license of any type.
3. Behavioral health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in the United States or non-war zones outside the United States.
4. Behavioral health services received after the date your coverage under the Policy ends. This applies to all behavioral health services, even if the behavioral health service is required to treat a medical condition that started before the date your coverage under the Policy ended.
5. Behavioral health services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Charges in excess of the Allowed Amount or in excess of any specified limitation. This exclusion does not apply when we arrange access to medically appropriate care from a qualified out-of-Network provider if medically appropriate care cannot be provided within the Network. You will only be responsible for paying cost-sharing in an amount equal to the cost-sharing you would have paid for provision of that or a similar service in-Network.
7. Custodial care.
8. Herbal medicine, herbal drugs, holistic or homeopathic treatment, and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*.
9. Nutritional counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.
10. Weight reduction or weight control programs.
11. Supplies, equipment and similar incidental services and supplies for personal care, comfort or convenience. Examples include but are not limited to:
    - Air conditioners and air purifiers.
    - Beauty/barber service.
    - Exercise equipment.
    - Guest service.
    - Personal computer.
    - Telephone.

- Television.

12. Equipment including light boxes, durable medical equipment, medical devices, supplies, or appliances of any kind whether associated with a behavioral or non-behavioral condition.
13. Private duty nursing.
14. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
15. Charges for missed appointments.
16. Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation programs or lifestyle programs, including any services provided in conjunction with, or as a part of, such programs.
17. Speech therapy, occupational therapy, physical therapy, and any other rehabilitative or habilitative therapy services.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for health care services that you receive before your effective date of coverage.

What If You Are Hospitalized When Your Coverage Begins?

If you are an inpatient in a Hospital on the day your coverage begins, we will pay Benefits for Covered Behavioral Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Behavioral Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Behavioral Health Services from Network providers.

What If You Are Eligible for Medicare?

Your Benefits may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but do not follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms*.

Eligible Persons must live within the United States.

Dependent

Dependent generally refers to the Subscriber's Spouse, Domestic Partner and children. All references to the Spouse of a Subscriber shall include a Domestic Partner. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

All newborn Dependent children of the Subscriber are covered from the moment of birth. All newly adopted Dependent children of the Subscriber are covered from and after the moment the child is placed in the physical custody of the Subscriber for adoption. However, the Subscriber must complete an enrollment form for all newborn and all newly adopted Dependent children within 31 days of the event.

Coverage for other Dependents listed above begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for due to situations allowing for a rescission (fraud or intentional misrepresentation of a material fact), or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program* (the Healthy Families Program, the Access for Infants and Mothers (AIM) Program or the Medi-Cal program in California). Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan, including the Healthy Families Program, the Access for Infants and Mothers (AIM) Program or the Medi-Cal program, at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period or the Eligible Person or Dependent is employed by an employer that offers multiple health benefit plans and the person elected a different plan during Open Enrollment; and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including termination of employment, reduction in the number of hours of employment, legal separation, divorce or death).
    - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.
    - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
    - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
    - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program* (the Healthy Families Program, the Access for Infants and Mothers (AIM) Program or the Medi-Cal program in California). Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 60 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Behavioral Health Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any Behavioral Health Services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the date we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later.

- **Subscriber Retires or Is Pensioned**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the date the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's *Application*, and only if the Subscriber continues to meet any applicable eligibility requirements. The Group can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

If we can demonstrate that you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, we may rescind or cancel your coverage, with written notice of your right to appeal.

After 24 months following the issuance of the Policy, we will not rescind the Policy for any reason, and will not cancel the Policy, limit any of the provisions of the Policy, or raise the Policy Charge due to any omissions, misrepresentations or inaccuracies in the application form, whether willful or not.

If we rescind or cancel your coverage, we will send the Group and the Subscriber a written notice via certified mail at least 30 days prior to the effective date of rescission or cancellation explaining the reasons for the intended rescission or cancellation and information on how to file an appeal of the decision with the California Department of Insurance. In addition, in the event it is found you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, We may cancel your coverage, as permitted by law. Should your coverage be rescinded due to fraud, or an intentional misrepresentation of a material fact, we may take any and all actions allowed by law, which may include demanding that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

Review by the California Department of Insurance for Improper Cancellation, Rescission or Non-Renewal of Coverage

You may request a review by the California Insurance Commissioner if you believe your Policy or coverage has been or will be wrongly canceled, rescinded or not renewed. Contact the California Insurance Commissioner's Consumer Communications Bureau at **1-800-927-HELP (4357)** or **TTY 1-800- 482-4833** to receive assistance with this process, or submit an inquiry in writing to:

California Department of Insurance

Consumer Communications Bureau

300 S. Spring Street, South Tower

Los Angeles, CA 90013

Or through the website **http://www.insurance.ca.gov.**

Coverage for a Disabled Dependent Child

Continued Enrollment of a Disabled Dependent Child

Coverage for an Enrolled Dependent child who is disabled will not end just because the child has reached 26 years old. We will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because a physically or mentally disabling illness or health condition.
- The Enrolled Dependent child depends chiefly on the Subscriber for support.

At least 90 days prior to the date the Enrolled Dependent child attains the limiting age, we will notify the Subscriber that the Enrolled Dependent child's coverage will end upon attainment of the limiting age, unless the Subscriber submits proof of the criteria described above to us within 60 days of the date of receipt of our notification. Upon receipt of the request of the Subscriber for continued coverage of the child and proof of the criteria described above, we will notify the subscriber of confirmation of the extended coverage.

If we fail to notify the Subscriber prior to the date of the Enrolled Dependent attaining age 26, coverage of the Enrolled Dependent child will continue pending confirmation the Enrolled Dependent meets the criteria.

We may continue to ask you for proof that the child continues to be disabled and dependent. We will not ask for this information more than once a year after a two-year period following the child's attainment of the limiting age.

If the Subscriber or Covered Person changes carriers to another insurer or to a health care service plan ("plan"), the new insurer or plan will continue to provide coverage for the Dependent child. The new insurer or plan may request information about the Dependent child initially and not more frequently than annually thereafter to confirm the Dependent child continues to satisfy the following criteria:

- Is not able to be self-supporting because of a physically or mentally disabling illness or health condition.

- Depends chiefly on the Subscriber for support.

The Subscriber or Covered Person must submit the information requested by the new insurer or plan within 60 days of receiving the request.

Initial Enrollment of a Disabled Child

A disabled Dependent child who is age 26 or older will be continued to be enrolled under the Policy if he or she is enrolled at the time he or she attains age 26, provided that satisfactory evidence of such disability is provided to us during the period commencing 60 days before and ending 60 days after the Dependent child's 26th birthday.

Continuation of Coverage

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Extension of Continuation Coverage under State Law (Cal-COBRA) after Exhaustion of Federal COBRA Continuation Coverage

A qualified beneficiary is an individual who was covered under the Policy and has also exhausted their continuation coverage under Federal law (COBRA) for which they were entitled to less than 36 months of coverage. Extended continuation coverage under state law (Cal-COBRA) may be obtained for up to 36 months from the date that the COBRA continuation began.

Qualifying Events for Continuation Coverage under State Law (Cal-COBRA)

The date of your "Qualifying Event" is the date that continuation coverage began under your federal COBRA continuation.

Notification Requirements and Election Period for Continuation Coverage under State Law (Cal- COBRA)

Notification of any right to extended coverage under Cal-COBRA will be provided to you by us within 90 days prior to your termination under COBRA. Continuation must be elected within 30 days of when COBRA continuation is scheduled to end.

The Group or the Group's designated plan administrator will notify us of your election to extend your continuation coverage under Cal-COBRA.

Termination Events for Continuation Coverage under State Law (Cal-COBRA)

Continuation under the Policy will end on the earliest of the following dates:

- Thirty-six months from the date of your qualifying event.
- The date, after electing continuation coverage, that the qualified beneficiary first becomes entitled to Medicare.
- The date, after electing continuation coverage that the qualified beneficiary has other hospital, medical or surgical coverage, or is or becomes covered under another group health plan.
- The date the qualified beneficiary is covered, becomes covered, or is eligible for coverage pursuant to Chapter 6A of the Public Health Service Act.
- The date coverage terminated under the Policy for failure to make timely payment of the Premium.
- The date the entire Policy ends.
- The date coverage would otherwise terminate under the Policy as described in this section under the heading Events Ending Your Coverage.

Special Provisions for Union Employee if Work Stops due to a Labor Dispute

If some or the entire Premium for the Policy is paid by the Group under the terms of a collective bargaining agreement, this provision will apply to Subscribers whose employment is covered by the agreement.

Work may stop due to a labor dispute. The Policy and all insurance will continue during the dispute as long as Premium is paid to us. Continuation is subject to the other sections of this provision.

Insurance will continue under this provision only for those Subscribers who are insured on the date work stops who continue to pay their contributions and also assume and pay the Group's contributions. The Group will send the contributions to us.

The Union that represents the Subscribers will collect the Subscribers' contributions. At least 75% of the Subscribers who were in the collective bargaining unit on the date work stopped must be making contributions. The Union will send the contributions to us.

Insurance coverage will continue as long as we receive Premium payments on or before each due date, subject to the grace period and the next paragraph.

If any Premium payment was due but had not been paid at the time work stopped, insurance will continue under this provision only if the Group pays that overdue Premium before the next Premium due date. If we accept Premium from the Group more than 31 days after the Premium due date, we will accept Premium for the same period of time from the Union representing the Subscribers.

The Subscribers' contributions per month that work is stopped will be figured as follows and will be increased as stated in the next paragraph:

- The Premium rates for the Policy on the date work stops may be stated as a set amount per Subscriber. Each Subscriber's contribution will be the rate or rates for the Subscriber's group.
- The Premium rates may not be stated as a set amount per Subscriber. Each Subscriber's contribution will be an average rate figured from the Policy's Premium rates and the amounts of insurance shown in Exhibit 2.

During the period that work is stopped each separate Premium rate in effect on the date work stops will be increased by 20%. Each Subscriber's contribution will be increased by 20%. We may agree to a smaller increase.

We will still have the right to increase or decrease Premium rates at any time in accordance with the terms of the Policy. We will have this right at any time that we would have had this right if work had not stopped. If we change the Premium rates, the change will be effective in accordance with the terms of the Policy regardless of any other sections of this provision.

Insurance will continue according to this provision until the earliest of the following:

- The date stated in a notice from us to the Union. A notice will be sent when less than 75% of the Subscribers who were in the collective bargaining unit on the date work stopped are insured.
- The date the Subscriber is employed by an employer other than the Group.
- 6 months after the date work stopped.

This provision can be extended to apply to other groups of Subscribers away from work due to a labor dispute if we agree.

Section 5: How to File a Claim

How Are Covered Behavioral Health Services from Network Providers Paid?

We pay Network providers directly for your Covered Behavioral Health Services. If a Network provider bills you for any Covered Behavioral Health Services, contact us. However, you are required to meet any applicable deductible and to pay any required Co-payments and Co-insurance to a Network provider.

How Are Covered Behavioral Health Services from an Out-of-Network Provider Paid?

When you receive Covered Behavioral Health Services from an out-of-Network provider, you are responsible for requesting payment from us.

Notice of Claim: Written notice of claim must be furnished to us within 20 days after a covered loss occurs or begins, or as soon thereafter as reasonably possible.

Proof of Loss: Written proof of loss must be provided to us within 90 days after the date the service was received. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give poof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Forms: Upon receipt of a written notice of a claim, we will provide you with claim forms for filing proof of loss. If we do not provide claim forms to you within 15 days after we receive written notice of a claim from you, you will have deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the timeframe for fling a proof of loss (as described above), written proof covering the occurrence, the character and the extent of the loss for which the claim is made.

As a third alternative, you may provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the behavioral health condition began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us.

Payment of Benefits

We will pay Benefits within 30 days after we receive your request for payment that includes all required information.

We will reimburse claims or any portion of any claim, whether in-state or out-of-state, for Covered Behavioral Health Services, as soon as possible, no later than 30 working days after receipt of the claim.

However, a claim or portion of a claim may be contested or denied by us. In that case, you will be notified in writing that the claim is contested or denied within 30 working days of receipt of the claim. The notice that the claim is being contested or denied will identify the portion of the claim that is contested or denied and the specific reasons including, for each reason, the factual and legal basis known at the time by us for contesting or denying the claim. If the reason is based solely on facts or solely on law, we will provide only the factual or the legal basis for contesting or denying the claim. We will provide a copy of such notice to each Covered Person who received services pursuant to the claim that was contested or denied and the health care provider that provided the services at issue.

If an uncontested claim is not reimbursed by delivery to your address of record within 30 working days after receipt, we will pay interest at the rate of 10% per annum beginning with the first calendar day after the 30-working-day period.

If you provide written authorization to allow this, all or a portion of any Allowed Amount due to a provider may be paid directly to the provider instead of being paid to the Subscriber. We will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

Section 6: Questions, Complaints and Appeals

IMPORTANT NOTICE - CLAIM DISPUTES

Should a dispute concerning a claim arise, contact us first. If the dispute is not resolved contact the California Department of Insurance.

Call us at the phone number shown on your ID card.

Call the California Department of Insurance at:

- **1-800-927-HELP (4357)**
- **1-800-482-4833 (TTY)**

You may write the California Department of Insurance at:

California Department of Insurance

Claims Services Bureau, 11th Floor

300 South Spring Street

Los Angeles, CA 90013

Or through the website **http://www.insurance.ca.gov**.

For further information about complaint procedures please read the section below.

IMPORTANT NOTICE - NETWORK PROVIDER ACCESSIBILITY COMPLAINTS

If you have a complaint regarding your ability to access Covered Behavioral Health Services from a Network provider in a timely manner, call the telephone number shown on your ID card. If you would rather send your complaint to us in writing, a representative can provide you with the appropriate address. If your complaint is not resolved, you may contact the California Department of Insurance.

Call the California Department of Insurance at:

- **1-800-927-HELP (4357)**
- **1-800-482-4833 (TTY)**

You may write the California Department of Insurance at:

California Department of Insurance

Consumer Communications Bureau

300 South Spring Street, South Tower

Los Angeles, CA 90013

Or through the website **http://www.insurance.ca.gov**.

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

What to Do if You Disagree with Our Adverse Benefit Determination?

If you disagree with our Adverse Benefit Determination, you may file a formal appeal. Our internal review appeals procedures are designed to deliver a timely response and resolution to your appeal. We will continue to provide coverage for the Covered Behavioral Health Service under review until the Adverse Benefit Determination is resolved.

An Adverse Benefit Determination is any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be an Experimental or Investigational Service or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular Benefit at that time).

Post-service Claims

Post-service claims are claims filed for payment of Benefits after behavioral health care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a behavioral health professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the

sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the Adverse Benefit Determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to Urgent Requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. (For procedures associated with non-Urgent Requests for Benefits based on Medical Necessity for Benefits, see *Non-Urgent Pre-Service Requests Based on Medical Necessity* below.)
- For appeals of post-service claims as defined above, the appeal will take place and you will be notified of the decision within 30 days of the receipt of information that is reasonably necessary to make this determination. The determination will be communicated to the provider in a manner that is consistent with current law.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Non-Urgent Pre-Service Requests Based on Medical Necessity

Decisions to deny or modify requests for authorization of Covered Behavioral Health Services, based on Medical Necessity, are made only by licensed Physicians or other appropriately licensed health care professionals. The reviewer makes these decisions within at least the following time frame required by state law:

- Decisions to approve, modify or deny requests for authorization of Covered Behavioral Health Services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of your condition, not to exceed five business days from our receipt of the information reasonably necessary and requested to make the decision.
- If your condition poses an imminent and serious threat to their health, including, but not limited to, potential loss of life, limb or other major bodily function, or if lack of timeliness would be detrimental in regaining maximum function or to your life or health, the decision will be rendered in a timely fashion appropriate for the nature of your condition, but not later than 72 hours after our receipt of the information reasonably necessary and requested by the reviewer to make the determination (an Urgent Request).

If the decision cannot be made within these time frames because: (1) we are not in receipt of all of the information reasonably necessary and requested or (2) consultation by an expert reviewer is required, or (3) the reviewer has asked that an additional examination or test be performed upon you, provided the examination or test is reasonable and consistent with good medical practice, the reviewer will notify the Physician and you, in writing, upon the earlier of the expiration of the required time frame above or as soon as we become aware that they will not be able to meet 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 us, the reviewer shall approve, modify or deny the request for authorization within the time frame specified above as applicable.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Request for Benefits, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be decided within 5 business days of the request.

We will provide continued coverage pending the outcome of an appeal. We will not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Denial of Experimental, Investigational or Unproven Services

If we deny Benefits for a medical procedure or plan of treatment as being Experimental or Investigational Services or Unproven Services and those services are for a Life-Threatening or seriously debilitating condition, we will provide you with written notification of all of the following:

- Written notice within 5 business days describing how you can request an external review of any decision that denies Experimental or Investigational Services or Unproven Services.
- The specific medical and scientific reasons for the denial and specific references to pertinent Policy provisions upon which the denial is based.
- A description of the alternative medical procedures or treatments covered by the Policy, if any.
- A description of the process of external review explaining how you or your representative can appeal the denial and participate in the review. An external review will be provided to you within 30 calendar days following the receipt of a request for external review. An expedited review may be held within 5 business days at the request of the treating Physician.

For purposes of this section, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

Independent External Review Program

If we deny Benefits because it was determined that the treatment is not Medically Necessary or was an Experimental, Investigational or Unproven Service, you may request an independent medical review (IMR) from the California Department of Insurance (CDI) at no cost to you. However, you must first file an appeal of the denial with us.

First Steps: Appeal the denial using our internal appeals/grievance process.

- Find out the reason for the denial and review the Policy language supporting the denial.
- Submit all necessary support for treatment, with doctor(s) statements and medical records.
- Provide research showing the treatment requested is accepted and appropriate, if possible.

IMR Deadlines: If we uphold our decision or delay responding to your appeal/grievance, then you may file a Request for Assistance or an IMR request with the California Department of Insurance. This request must be made within 6 months of our upholding the decision on appeal.

Getting Independent Medical Review: In this process, expert independent medical professional review the medical decisions made by us and often decide in favor of you getting the medical treatment requested.

An IMR can be requested if our decision involves:

- Health claims that have been denied, modified, or delayed by us because a Covered Behavioral Health Service or treatment was not considered Medically Necessary;
- Health claims that have been denied for urgent or emergency services that a provider recommended was Medically Necessary;
- Health claims that have been denied as being Experimental, Investigational or Unproven Services.

The results of an external review requested for Experimental, Investigational or Unproven Services can be rendered in seven days if you suffer from a terminal illness and your Physician requests an expedited review.

6 Easy Steps to IMR:

1. Notify CDI to request an IMR and fill out an application.
2. Agree and provide written consent to participate in IMR.
3. The CDI determines if the request is eligible for IMR.
4. The IMR Organization will have 30 days to review once all information is gathered--unless the request involves an imminent and serious threat to health, which can be expedited and a decision rendered in 3 days.
5. The IMR organization will send the decision to you, Unimerica Life Insurance Company, and the California Insurance Commissioner.
6. The California Insurance Commissioner will adopt the recommendation of the IMR organization and promptly notify you and us. The decision is binding on Unimerica Life Insurance Company.

Reviewing Coverage Denials: If we deny treatment as not a Covered Behavioral Health Service, or if CDI finds that the issue does not involve a disputed health care service, CDI will review our decision for correctness.

Contact us at the telephone number shown on your ID card for more information on the independent external review program.

Contact the California Department of Insurance:

You may contact the California Department of Insurance for information on the independent external review program by calling:

- **1-800-927-HELP (4357)**
- **1-800-482-4833 (TTY)**

You may also write the California Department of Insurance at:

California Department of Insurance

Claims Services Bureau, 11th Floor

300 South Spring Street

Los Angeles, CA 90013

Or through the website **http://www.insurance.ca.gov**.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is based on California regulations.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies when a person has behavioral health coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan**. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan**. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

For purposes of this section, terms are defined as follows:

A. **Plan**. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group, blanket, franchise and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; medical benefits under group or individual automobile contracts; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of any such policy contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the behavioral health benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing behavioral health benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as

dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has behavioral health coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. **Allowable Expense.** Allowable Expense is a behavioral health expense, including deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

   The following are examples of expenses or services that are and are not Allowable Expenses:

   1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

   2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

   3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

   5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. **Closed Panel Plan.** Closed Panel Plan is a Plan that provides behavioral health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent.** Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

What Are the Rules for Determining the Order of Benefit Payments?

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's behavioral health expenses or behavioral health coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no behavioral health coverage for the dependent child's behavioral health expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's behavioral health expenses or behavioral health coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the behavioral health expenses or behavioral health coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's behavioral health expenses or behavioral health coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other behavioral health coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other behavioral health coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are secondary to Medicare, we will pay Benefits under this Coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:

- You are eligible for, but not enrolled in, Medicare and this Coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating this Coverage Plan's Benefits in these situations for administrative convenience, we may, as we determine, treat the provider’s billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the Allowable Expense for both this Coverage Plan and Medicare.

Right to Receive and Release Needed Information

Certain facts about behavioral health coverage and services are needed to apply these COB rules and to find out benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Does This Plan Have the Right of Recovery?

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We offer behavioral health coverage to Eligible Persons with a physical handicap under the same terms and conditions as are offered to Eligible Persons without a physical handicap. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Policy will cover or pay for the behavioral health that you may receive. The Policy pays for Covered Behavioral Health Services, which are more fully described in this *Certificate*.
- The Policy may not pay for all treatments you or your Physician may believe are needed. Your right to Benefits is limited to the Covered Behavioral Health Services described in *Section 1: Covered Behavioral Health Services*. If you choose to receive a service that is not a Medically Necessary Covered Behavioral Health Service under the Policy, you will be responsible for paying all charges and no Benefits will be paid.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

What Is Our Relationship with Providers and Groups?

The relationships between us and Network providers and Groups are solely contractual relationships between independent contractors. Network providers and Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Groups.

We do not provide behavioral health services or supplies, or practice medicine. We arrange for behavioral health providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not responsible for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Groups?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount that is a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your provider, the cost of any non-Covered Behavioral Health Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

We will provide notice to the Group and all affected Subscribers if either of the following occurs:

- **For discontinuance of a particular behavioral health benefit plan.** Your coverage may be terminated if we decide to cease offering the a particular behavioral health benefit plan upon 90 days written notice to the California Department of Insurance, the Group and all affected Subscribers covered under the behavioral health benefit plan. When a behavioral health benefit plan is discontinued, we will make all other behavioral health benefit plans offered to new group business available to the Group without regard to the claims experience of behavioral health-related factors of insureds or individuals who may become eligible for the coverage.
- **For discontinuance of all new and existing behavioral health benefit plans.** Your coverage may be terminated if we decide to cease offering existing or new plans in the group market in the State of California upon 180 days written notice to the California Department of Insurance, the Group and all affected Subscribers covered under the behavioral health benefit plans..

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy, including fraud or an intentional misrepresentation of a material fact, after twenty-four (24) months from the date of issuance of the Policy.

Do We Pay Incentives to Providers?

We pay Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of behavioral health services in a cost efficient and effective manner. These financial incentives are not intended to affect your access to behavioral health services.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.

- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain behavioral health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's behavioral health services is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective manner. In some instances, these programs may be offered in combination with a non-related entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. Contact us at www.liveandworkwell.com or the telephone number on your ID card if you have any questions.

Who Interprets Benefits and Other Provisions under the Policy?

We will do all of the following:

- Pay Benefits according to the Policy.
- Pay Benefits according to this Policy and subject to other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.
- Other persons or entities may provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Behavioral Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we have the right to change, withdraw or add Benefits or end the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning behavioral health services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements you may contact your behavioral health provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Physical Examinations and Autopsy: We, at our own expense, shall have the right and opportunity to examine you when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Is Workers' Compensation Affected?

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

How Are Benefits Paid When You Are Medicare Eligible?

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Reimbursement - Right to Recovery

In consideration of the coverage provided by this *Certificate of Coverage*, we shall have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, if you make a recovery from any or all of the following listed below:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.
- These third parties and persons or entities are collectively referred to as "Third Parties".

You agree as follows:

- That you will cooperate with us in protecting our right to reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the reimbursement claim,
  - responding to requests for information about any accident or injuries, and
  - making court appearances, we will not require you to travel more than 60 miles from home for a court appearance without reimbursing your reasonable expenses.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with

such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.

- That benefits paid by us may also be considered to be benefits advanced. Benefits are considered benefits advanced where it is either now known or later known that some other party may be the primary payor. Benefits advanced will be expected to be repaid through either coordination and/or reimbursement.
- You agree to advise us, in writing, within a reasonable time of your claim against the third party and to take such action, provide such information and assistance, and execute such documents as we may reasonably require to facilitate enforcement of the claim. We may have a right to a lien, to the extent of benefits advanced, upon any recovery that you receive from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise.
- That the provisions of this section will apply to your survival claim, estate, and/or the personal representative of your estate.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- Our files contain clear, documented evidence of an overpayment and written authorization from you or assignee, permitting the reimbursement or withholding procedure or
- Our files contain clear, documented evidence of the following:
  - The overpayment was erroneous under the provisions of the Policy.
  - The error which resulted in the payment is not a mistake of the law.
  - We notify you within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosure of claimants or third parties, we notify you within fifteen (15) calendar days after the date of discovery of such error. The date of the error will be the day on which the draft for Benefits is issued.
  - The notice clearly states the cause of the error and states the amount of the overpayment.
  - The procedure described above may not be used if the overpayment is the subject of a reasonable dispute as to facts.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

If you do not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Policy.

The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Change of Beneficiary

The right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy or to change of beneficiary or beneficiaries, or to any other changes in this Policy. Please refer to *Section 3: When Coverage Begins* for information on who is eligible for coverage under the Policy.

Non-Discrimination in Contract Availability or Terms

No admitted insurer, licensed to issue disability insurance, shall fail or refuse to accept an application for that insurance, to issue that insurance to an applicant therefore, or issue or cancel that insurance, under conditions less favorable to the Eligible Person than in other comparable cases, except for reasons applicable alike to persons of every race, color, religion, sex, gender, gender identity, gender expression, national origin, ancestry or sexual orientation.

Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof is required to be furnished.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Benefits*, the Group's *Application* and any Riders and/or Amendments, make up the entire Policy between the parties, and any statement made by the Group shall, in absence of fraud, be deemed a representation and not a warranty. No statement made by any Eligible Person who eligibility has been accepted by us shall avoid the insurance or reduce the Benefits under this Policy or be used in defense to a claim hereunder.

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Section 9: Defined Terms

Adverse Benefit Determination - Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is an Experimental or Investigational Service or not Medically Necessary or appropriate. An adverse benefit determination also includes any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular Benefit at that time).

Allowed Amounts - for Covered Behavioral Health Services, incurred while the Policy is in effect, Allowed Amounts are explained in the *Schedule of Benefits*.

Allowed Amounts are calculated solely in accordance with our reimbursement policy guidelines. We develop these guidelines after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source.

Alternate Facility - a behavioral health facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Behavioral Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - the total of the Allowed Amount you must pay for Covered Behavioral Health Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amount. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Autism Spectrum Disorder - including pervasive developmental disorder, is a condition defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Behavioral Health Treatment - professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a Covered Person with pervasive developmental disorder or Autism Spectrum Disorders, and that meet all of the following criteria:

- The treatment is prescribed by a Physician and surgeon licensed pursuant to Chapter 5

(commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the California Business and Professions Code.

- The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
  - A qualified autism service provider.
  - A qualified autism service professional supervised and employed by the qualified autism service provider.
  - A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific Covered Person being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:
  - Describes the Covered Person's behavioral health impairments to be treated.
  - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Covered Person's progress is evaluated and reported.
  - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or Autism Spectrum Disorders.
  - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to us upon request.

In applying the above definition, "qualified autism service provider," qualified autism service professional," and "qualified autism service paraprofessional" shall have the following meanings:

- "Qualified autism service provider" means either of the following:
  - A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or Autism Spectrum Disorders, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.
  - A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or Autism Spectrum Disorders, provided the services are within the experience and competence of the licensee.
- "Qualified autism service professional" means an individual who meets all of the following criteria:
  - Provides Behavioral Health Treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
  - Is supervised by a qualified autism service provider.

- Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.
- Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program.
- Has training and experience in providing services for pervasive developmental disorder or Autism Spectrum Disorders pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code.
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

- "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:
  - Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.
  - Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.
  - Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
  - Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.
  - Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

Benefits - your right to payment for Covered Behavioral Health Services that are available under the Policy.

Co-insurance - the charge, stated as a percentage of the Allowed Amount, that you are required to pay for certain Covered Behavioral Health Services.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Behavioral Health Services.

Please note that for Covered Behavioral Health Services, you are responsible for paying the lesser of the following:

- The Co-payment.
- The Allowed Amount.

Covered Behavioral Health Service(s) - those Mental Health Services and Substance Use Disorder Services which are all of the following:

- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Provider, facility or any other person.
- Described as a Covered Behavioral Health Service in this *Certificate* under *Section 1: Covered Behavioral Health Services* and in the *Schedule of Benefits*.
- Medically Necessary.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Covered Persons and providers, by calling the telephone number on your ID card.

Covered Person - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Dependent - the Subscriber's legal Spouse, Domestic Partner or a child of the Subscriber or the Subscriber's Spouse or Domestic Partner. All references to the Spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- An adopted child.
- A child placed for adoption.
- Any child for whom the Subscriber has assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by intentional assumption of parental status, or assumption of parental duties by the Subscriber, as certified by the Subscriber at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled. The term child does not include foster children.
- A child for whom behavioral health coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A Dependent includes a child age 26 is/or becomes disabled and dependent upon the Subscriber.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches age 26.

Enrollment may not be denied based on any of the following facts:

- The child does not reside with the Subscriber.

- The child is born out of wedlock.
- The child is not claimed as a dependent on the Subscriber's federal or state income tax.
- The child lives outside the service area.

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

If the Subscriber is required by a court or administrative order to provide health coverage for the Subscriber's child, the child will be able to be enrolled regardless of any enrollment season restriction. We will enroll the child upon application for enrollment by the custodial parent, the non-custodial parent, the Medi-Cal program, or the local child support agency.

We will not cancel or revoke enrollment of the child, or eliminate coverage, unless one of the following happens:

- The Group receives satisfactory written evidence that the order requiring coverage is no longer in effect.
- The Group receives confirmation that the child is enrolled in other comparable coverage that will take effect not later than the effective date of disenrollment under this Policy.
- The Group has eliminated dependent health coverage for all its Subscribers.
- The Subscriber is no longer eligible for coverage.

We will notify both parents and any other person having custody of a child in writing at any time that health insurance for the child is terminated.

When a child is enrolled in a plan of the non-custodial parent or a parent sharing custody or temporary control of the child, we will:

- Provide the custodial parent with any information necessary to obtain Benefits and services for the child under this Policy.
- Allow the custodial parent or the health care provider with the custodial parent's approval, to submit claims for Benefits, without the approval of the non-custodial parent.
- Make claim payments directly to the person or entity who submitted the claim, that is, the custodial parent, the health care provider, or the Medi-Cal program.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or condition; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Behavioral Health Services through live audio and video technology.

Domestic Partner - a person who has filed a declaration of domestic partnership with the California Secretary of State or a person who meets the eligibility requirements, as defined by the Group, and the following:

- Is eighteen (18) years of age or older. An exception is provided to Eligible Persons and/or Dependents less than 18 years of age who have, in accordance with California law, obtained:

- Written consent from the underage person's parents or legal guardian and a court order granting permission to the underage person to establish a domestic partnership.
- A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent or legal guardian capable of consenting to the domestic partnership.

- Is mentally competent to consent to contract.
- Is unmarried or not a member of another domestic partnership.
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy. An Eligible Person must live within the United States.

Emergency - a serious mental health or substance use disorder, condition or symptom manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected by the Covered Person to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

An Emergency also includes a psychiatric emergency medical condition which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Covered Person as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the Mental Disorder.

Emergency Behavioral Health Services - behavioral health services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other behavioral health services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination is made regarding coverage in a particular case, are any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- If you have a Life-Threatening or seriously debilitating condition (disease or conditions that cause major irreversible morbidity), we may consider an otherwise Experimental or Investigational Service to be a Covered Behavioral Health Service for that behavioral health condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit

unproven, the service has significant potential as an effective treatment for that behavioral health condition.

Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient behavioral health services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Life-Threatening - means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Medically Necessary – behavioral health services provided for the purpose of preventing, evaluating, diagnosing or treating a behavioral health condition, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following:

- In accordance with *Generally Accepted Standards of Medical Practice.*
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your behavioral health condition, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Not mainly for your convenience or that or your doctor or other health care provider.
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your behavioral health condition, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether behavioral health care services are Medically Necessary.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Care Services - Covered Behavioral Health Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - Mental Illness is defined as those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded in *Section 2: Exclusions and Limitations.*

Network - when used to describe a provider of behavioral health services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Behavioral Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Behavioral Health Services, but not all Covered Behavioral Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Behavioral Health Services and products included in the participation agreement and an out-of-Network provider for other Covered Behavioral Health Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Behavioral Health Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Behavioral Health Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount that you will pay per year which includes the Annual Deductible, Co-payments or Co-insurance (as applicable). The Out-of-Pocket Limit excludes Premiums, balance billing amounts for out-of-Network providers and your spending for non-covered services. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Per Occurrence Deductible - the portion of the Allowed Amount (stated as a set dollar amount) that you must pay for certain Covered Behavioral Health Services prior to, and in addition to, any Annual Deductible before we begin paying Benefits for those Behavioral Health Services.

When a plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Allowed Amount.

The *Schedule of Benefits* will tell you if your plan is subject to payment of a Per Occurrence Deductible and how the Per Occurrence Deductible applies.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law. Any psychologist, mental health clinical nurse, psychiatric-mental health nurse, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Group that includes all of the following:

- *Group Policy*.
- *Certificate*.
- *Schedule of Benefits*.
- Group *Application*.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Group.

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Residential Treatment - a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Behavioral Health Services not described in this *Certificate*. Covered Behavioral Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Behavioral Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Serious Emotional Disturbances - when a Enrolled Dependent child who has one or more mental disorders as identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. As a result of the disorder, one or more of the following is true:

- The child is at risk of removal from home or has been ill for more than six months.
- The child displays psychotic features, risk of suicide or risk of violence.
- The child meets special education eligibility requirements under state law.

Service Area - the State of California or any other geographical area within the state designated in the Policy within which Network provider services are rendered to Covered Persons for Covered Behavioral Health Services.

Severe Mental Illness - any of the following diagnosed Severe Mental Illnesses: schizophrenia or schizoaffective disorder, bipolar disorder (manic-depressive illness); major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or Autism Spectrum Disorders; anorexia nervosa; and bulimia nervosa.

Sickness - The term Sickness as used in this *Certificate* includes Mental Health Care and Substance Related and Addictive Disorders Services, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse - a person who is married to an Employee. All references to Spouse shall include a Domestic Partner. Please refer to the definition of *Domestic Partner*.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

Substance-Related and Addictive Disorders Services - Covered Behavioral Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Telehealth - means the mode of delivering Covered Behavioral Health Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the licensed health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

In applying the above definition, "asynchronous store and forward," "distant site," "originating site," and "synchronous interaction" shall have the following meanings:

- "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the licensed health care provider at a distant site without the presence of the patient.
- "Distant site" means a site where a licensed health care provider who provides Covered Behavioral Health Services is located while providing these services via a telecommunications system.
- "Originating site" means a site where a patient is located at the time Covered Behavioral Health Services are provided via a telecommunications system or where the asynchronous store and forward service originates.
- "Synchronous interaction" means a real-time interaction between a patient and a licensed health care provider located at a distant site.

Transitional Living - Mental health care services and substance-related and addictive disorders services provided through facilities, group homes and supervised apartments which provide 24-hour supervision and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be

used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Service(s) - services, including medications, that are not effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain behavioral health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific behavioral health services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.liveandworkwell.com.

Please note:

- If you have a Life-Threatening or seriously debilitating condition, an otherwise Unproven Service may be a Covered Behavioral Health Service for that behavioral health condition. Prior to such a determination, it must first be established that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that behavioral health condition.
- An otherwise Unproven Service may be a Covered Behavioral Health Service if you have a behavioral health condition that is not a Life-Threatening or seriously debilitating condition. For that to occur, all of the following conditions must be met:
    - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.
    - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
    - You must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
    - At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
    - The service must be available from a Network Physician and/or a Network facility.

Utilization Review - a pre-service, concurrent (ongoing) or post-service review and determination as to whether services and/or supplies are Covered Behavioral Health Services.

Urgent Request - any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or
- In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject

of the claim for medical care or treatment.

- In determining whether a claim for medical care or treatment involves urgent care, the individual acting on behalf of the plan will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician with knowledge of your medical condition determines that a claim involves urgent care, the claim for medical care or treatment will be treated as an urgent care claim.