AUHSD

Blue Cross PPO Member Plan

Evidence of Coverage & Disclosure

Outpatient & Inpatient Behavioral Health Services

January 1, 2018

Holman Professional Counseling Centers
Managed Behavioral Health Care Services

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Northridge, California 91324
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AUHSD Blue Cross PPO Member Plan

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Group Plan Contract which has been entered into between the Anaheim Union High School District, hereafter called "AUHSD" and Holman Professional Counseling Centers, hereafter called "HPCC." The Group Plan Contract must be consulted to determine the exact terms and conditions of coverage. Pursuant to California law, you have the right to view this EOC prior to enrollment in the HPCC Plan. This EOC discloses the terms and conditions of coverage and is only a summary of the terms of the HPCC Plan. Your Employer's Subscriber Group Contract must be consulted to determine the exact terms and conditions of your coverage. **Depending on whom you contact, a copy of the Group Plan Contract will be presented by HPCC or AUHSD to you upon request.**

This Evidence of Coverage and Disclosure Form discloses the terms and conditions of coverage. Any Eligible has a right to view the Evidence of Coverage prior to enrollment. This Evidence of Coverage and Disclosure Form should be read completely and carefully. Eligibles with special health care needs should read the sections that apply to them carefully.

This Evidence of Coverage and Disclosure Form incorporates by reference and includes as part of the total Agreement, those benefits and coverages outlined in the Group Contract and Benefit Schedule. If you have any questions about your benefits or how to use them, please contact:

Holman Professional Counseling Centers
9451 Corbin Ave., Suite 100
Northridge, California 91324
(800) 321-2843

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or Health Insurance Company. To get an interpreter or to ask about written information in (your language), first call your insurance company's phone number at 1-800-321-2843. Someone who speaks (your language) can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su plan de salud al 1-800-321-2843. Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Centro de ayuda de PPOal 1-800-927-4357.

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DEFINITION OF TERMS

1. **Acute Condition**. A medical condition of limited duration that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention.

2. **Acute Psychiatric Hospital**. Health facility with a medical staff that provides 24-hour inpatient care for behavioral health care patients.

3. **Annual Benefit Maximum**. Total amount of money HPCC will pay for authorized behavioral health services provided to Enrollees by Providers per year. Enrollee will be responsible for any behavioral health services beyond this amount.

4. **Benefits Schedule**. Describes the available levels of treatments provided through a Group Plan Contract, along with required co-payments.

5. **Contracted Provider**. A person licensed as a psychiatrist, psychologist, clinical social worker, marriage and family therapist, nurse, other licensed health care professional or qualified autism service provider, professional or paraprofessional with appropriate training and experience in behavioral health services, and who has contracted with HPCC to deliver specified services to HPCC Enrollees.

6. **Coordination of Benefits**. The allocation of financial responsibility between two or more insurance companies or health care providers, each with a legal duty to pay for covered services provided to an Enrollee at the same time.

7. **Co-payment**. Fixed fee paid pursuant to this Agreement to a Provider by Enrollee at time of provision of behavioral health services, which are in addition to the premiums paid by AUHSD. Such fees may be a specific dollar amount or a percentage of total fees, depending on the type of services provided.

8. **Coverage Decision**. The approval or denial of health care services by a plan, or by one of its contracting providers, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract.

9. **Covered Services**. Behavioral health services and supplies provided by Providers that are determined to be medically necessary and covered under a Group Plan Contract.

10. **Day Care Behavioral Health Services**. Includes the full range and scope of inpatient Behavioral Health Services, at both hospitals and facilities, except that the Enrollee stays overnight in a place other than the hospital or facility, usually, the Enrollee's home.

11. **Disputed Health Care Service**. Any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracted providers, in whole or in part due to a finding that the service is not medically necessary.

12. **Eating Disorder**. For purposes of this manual, means the diseases of anorexia nervosa and bulimia nervosa and eating disorder not otherwise specified, as defined by the Diagnostic and Statistical Manual (DSM-IV).

13. **Emergency**. The sudden onset of severe behavioral health symptoms and impairment of functioning due to a mental disorder or chemical dependency such that the absence of immediate attention could reasonably be expected to result in any of the following:

    - Enrollee's health is placed in serious jeopardy.
    - Serious impairment to bodily functions.
    - Serious dysfunction to any bodily organ or part.

    This includes an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

14. **Emergency Behavioral Health Services and Care.** Includes the screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

15. **Employer/Association/Union**. An organization that has contracted with HPCC to provide behavioral health care services to its eligible members.

16. **Enrollee**. An Eligible member (and/or such eligible member's eligible dependents) of a Group who has contracted with HPCC to provide Behavioral Health Services to its Eligible Members. All Eligible Members/dependents must meet eligibility requirements, be enrolled in the Anthem Blue Cross Plan, and accept the financial responsibility for any copayment that may be incurred in treatment through the HPCC Plan.

17. **Family Unit**. Comprised of Enrollee plus Enrollee's eligible dependents.

18. **Fraud**. The deliberate submission of false information by a provider, enrollee, plan member, or other individual or entity, to gain an undeserved payment on a claim.

19. **Group Plan Contract**. Agreement between AUHSD and HPCC providing that HPCC will provide behavioral health care services for AUHSD's eligible members in exchange for Premium paid by AUHSD.

20. **Group Therapy Session**. Goal-oriented behavioral health services provided in a small group setting by an HPCC provider. Group therapy sessions can be made available to the enrollee in lieu of individual outpatient therapy when appropriate.

21. **Hospital**. A health care facility including any acute care hospital or acute psychiatric facility who has entered into a provider agreement with HPCC to deliver a full range of mental health services on an inpatient treatment basis.

22. **Inpatient**. An Enrollee receiving Inpatient Behavioral Health Services in a Hospital.

23. **Inpatient Behavioral Health Services.** Behavioral health services provided on a 24-hour basis at a Hospital including all procedures utilizing psychological principles and methods for the understanding, diagnosis, and treatment of Enrollees with Mental Disorders and alcohol, chemical dependence, substance abuse or mental health problems.

24. **Language Assistance Program**. Plan shall establish and maintain an ongoing language assistance program to ensure Limited English Proficient ("LEP"). Enrollees have appropriate access to language assistance while accessing health care services as required by Language Assistance Program Regulations. Provider shall cooperate and comply, as applicable, with Plan's language assistance program; however, HPCC shall maintain ongoing administrative and financial responsibility for implementing and operating on an ongoing basis the language assistance program for Enrollees.

25. **Life Threatening Illness**. Includes 1) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; or 2) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

26. **Medical Detoxification**. Medically based supervised treatment for an unstable or acute medical condition resulting from withdrawal from chemical substances including drugs or alcohol.

27. **Medically Necessary**. Except were state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean mental health or substance related disorder services that a Licensed Mental Health Professional, exercising prudent clinical judgment, would provide to a member for the purpose of evaluating, diagnosing, or treating a mental or substance related disorder. Those services are:

    Appropriate and necessary for the diagnosis or treatment of the condition within standards of good clinical practice within the organization Behavioral Health community. They are also clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the member's condition.

28. **Mental Disorder**. A behavioral or psychological syndrome that causes significant distress or disability, or a significantly increased risk of suffering death, pain, or an important loss of freedom. The syndrome is considered to be a manifestation of some behavioral, psychological, or biological dysfunction in the person.

29. **Mental Health Services**. Goal-oriented behavioral health services for the treatment of mental disorders including substance abuse.

30. **Non-Contracted Provider**. Any provider not contracted with HPCC to deliver services to enrollees. Every effort will be made to ensure Enrollees are not subject to balance billing practices for services paid under the HPCC Agreement. A member may be liable to the non-contracted provider for the cost of services not covered by HPCC.

31. **Outpatient Behavioral Health Services**. Outpatient Behavioral Health Services are those Behavioral Health Services that are provided by a Provider in his or her office or appropriate outpatient setting.

32. **Premium**. Predetermined monthly membership fee paid by AUHSD for coverage under the Group Plan Contract.

33. **Prior Authorization**. Approval of coverage from HPCC prior to the Enrollee obtaining covered services. Requests for prior authorization will be denied if not Medically Necessary, if in conflict with HPCC's policies or otherwise are not covered services.

34. **Provider**. A person licensed as a psychiatrist, psychologist, clinical social worker, marriage, family and child counselor, nurse, other licensed health care professional or qualified autism service provider, professional or paraprofessional with appropriate training and experience in behavioral health services, working individually or within a corporation, clinic, or group practice, who is employed or under contract with HPCC to deliver behavioral health services to Enrollees.

35. **Qualified Autism Service Provider, Professional or Paraprofessional:** A health care provider under contract with HPCC who is acting within his or her scope of practice and who possesses adequate education, training and expertise (as defined by HPCC in accordance with applicable state regulation(s) pursuant to state law) related to the particular condition(s) of the Enrollee.

36. **Qualified Health Care Professional**. A licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular condition(s) of the Enrollee.

37. **Residential Treatment Center**. A facility which provides a specific behavioral treatment program on a live-in basis pursuant to a written treatment plan approved and monitored by a practitioner, and which facility is also licensed, certified or approved as such by the appropriate state agency.

38. **Serious Chronic Condition**. A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that does either of the following:

    1. Persists without full cure or worsens over an extended period of time;
    2. Requires ongoing treatment to maintain remission or prevent deterioration.

39. **Serious Debilitating Illness**. Diseases or conditions that cause major irreversible morbidity.

40. **Sub-Acute Care Facility**. Any licensed behavioral health, mental health or substance abuse residential treatment facility that has entered into a provider agreement with HPCC to deliver the full range of community treatment services, both on an inpatient and day care basis. Referral of Enrollees to a facility shall be made, where appropriate, as an alternative to hospital care.

41. **Treatment Plan**. A written clinical presentation of the Provider's diagnostic impressions and therapeutic intervention plans. The behavioral health treatment plan is submitted routinely to the HPCC clinician for review as part of the concurrent review monitoring process.

42. **Urgently Needed Behavioral Health Care Services**. Medically Necessary behavioral health services required outside of the service area to prevent serious deterioration of an Enrollee's behavioral health resulting from sudden onset of illness or injury manifesting itself by acute

behavioral health symptoms of sufficient severity, such that treatment cannot be delayed until the Enrollee returns to the service area.

43. **Utilization Management Committee (UMC)**. A committee operating within HPCC whose function is to assure both quality and cost-effectiveness of treatment.

44. **Visit Outpatient**. An outpatient session with a Provider conducted on an individual or group basis during which behavioral health services are delivered.

ELIGIBILITY

Who Is Eligible?
All members covered by Anthem Blue Cross PPO under AUHSD's Group Plan and their eligible dependents are enrolled with the HPCC plan if they have met the eligibility requirements defined by AUHSD and Anthem Blue Cross.

Who Is An Eligible Dependent?
For determination of who qualifies as an eligible dependent, please see the applicable section in your Anthem Blue Cross plan Evidence of Coverage booklet.

What If My Dependent Is Also A Covered Member?
You may not be covered as a member and dependent, and your dependents may not be covered by more than one member. If you are a member who is also a dependent, you will be insured solely as a member. If you and your spouse belong to different health care plans, each of your children, stepchildren and legally adopted children may be insured under one plan only. If two members and/or their dependents have dual HPCC coverage, all co-payments for HPCC network providers will be waived.

When Does Coverage Begin?
Coverage begins coincident with coverage under the AUHSD/ Anthem Blue Cross Plan. For late enrollment and special enrollment provisions, see the applicable section within the Anthem Blue Cross Plan Evidence of Coverage booklet.

Reinstatement Due To Member Status
If a member is terminated and he or she returns to active status as an AUHSD/ Anthem Blue Cross member, such member and his or her eligible dependents may again become eligible.

USING THE HPCC PLAN

Step 1:
HPCC wants to provide the best service possible to its Enrollees. HPCC can be reached twenty-four (24) hours a day, seven (7) days a week. Just dial HPCC's toll-free number, **1-800-321-2843**, to talk to a HPCC representative. Tell the HPCC representative that you are an Enrollee or an Eligible Dependent, and the name of your trust. The HPCC representative will gather basic information about you. You may obtain a list of available contracted providers & contracted providers with Law Enforcement experience at www.HolmanGroup.com, User Name: AUHSD and Password: AUHSD2015 to select a HPCC contracted provider. Once a HPCC contracted provider has been

selected from the HPCC Website, HPCC must be called and informed of the providers selected by the AUHSD member.

Step 2: Emergencies, crisis or urgent care

If you have a medical emergency, you should dial "911" for the emergency response system if such an emergency service is established and operating in your area. If it is a **behavioral health emergency**, you must contact HPCC as soon as reasonably possible. HPCC must coordinate continuing and follow-up behavioral health services to emergency treatment. HPCC may elect to transfer you to an HPCC provider if such transfer would not create any unreasonable risk with your care as decided by HPCC's Medical Director. HPCC handles emergencies immediately upon contact.

Step 3:

If you have a non-emergency, call HPCC and explain the service you are interested in utilizing or the problem you are experiencing. The HPCC representative will ask you a series of questions to determine what treatment is Medically Necessary. Regular appointments are booked within a few working days of your call. An HPCC representative will call you back in most cases the same day you call in, and schedule your appointment with a Provider. All authorizations for non-emergency care will be decided within five (5) working days of the request. Upon enrollee request, HPCC will disclose its processes, including criteria and guidelines, for authorizing, modifying or denying services.

Step 4:

After the initial session(s) with an HPCC provider, the provider will submit a clinical assessment to HPCC's Outpatient or Inpatient Care Department. HPCC's Outpatient or Inpatient Care Department will review the clinical assessment. If your care is complete, your case will be turned over to HPCC's Utilization Review Department for record-keeping and quality assessment. If you require further treatment, HPCC's Utilization Review Department will send out a renewal form to the Provider. The provider will return the renewal form to the Outpatient or Inpatient Care Department with future treatment recommendations.

Step 5:

HPCC's Outpatient/Inpatient Care Department will review the treatment recommendation and approve the next set of sessions based on Medical Necessity. If future outpatient care is not Medically Necessary, your file will be turned over to HPCC's Utilization Management Committee (UMC) for a second review. If future inpatient care is not Medically Necessary, your file will be turned over to HPCC's Medical Director for a second review. The UMC or Medical Director will review, discuss, and assess your previous treatment and make sure that medical necessity was based on appropriate objective standards. If the UMC or Medical Director determines that more treatment is Medically Necessary, the treatment will be authorized within five (5) working days of the request. If the UMC or Medical Director determines that more treatment is not Medically Necessary, the treatment will be denied and you will be notified in writing of the reasons for the denial and shall be informed of the right to file a grievance with the Plan.

GENERAL PROVISIONS

Pre-payment Fees

AUHSD will pay monthly fees for each eligible member as stipulated in the Group Contract Agreement. These fees are renewable and negotiated as per the language in that same Agreement.

Co-payment

Enrollee and enrollee's eligible dependent(s) are responsible for the co-payment amounts specified in the Benefits Schedule (incorporated by reference). The co-payment amount may be a specific dollar amount or a percentage of the provider's charge depending on the service provided. The Enrollee will not be liable for any sums owed to the Provider by HPCC should HPCC default under the terms of its Provider Agreement. HPCC has systems in place so enrollees have one accumulated deductible and one out of pocket maximum amount. HPCC exchanges timely data with your primary medical plans. Your confirmation of your deductibles and co-payments are tracked on every Explanation of Benefits ("EOB") you receive. Please contact the HPCC at 1-800-321-2843 for any questions or need additional information.

Confidentiality

HPCC will maintain the confidentiality of all Enrollee records except to the extent that disclosure is authorized by the Enrollee in writing or is otherwise mandated or permitted by law.

A STATEMENT DESCRIBING HPCC'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Choice of Physicians and Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. An HPCC Clinician or Care Access Specialist will refer you to HPCC Providers in your community. Enrollees may choose a HPCC In-Network Provider from HPCC's web site. Enrollees can log into www.HolmanGroup.com, User Name: AUHSD and Password: AUHSD2015. If the Enrollee uses a Non-Contracted Provider, the Enrollee may choose which Non-Contracted Provider to use and is responsible for arranging for services to be rendered and for any charges incurred except as outlined in the Benefits Schedule.

Concurrent Reviews

In order to determine continuing medical necessity for your treatment, concurrent reviews will occur on a regular basis. During such reviews an HPCC clinician monitors the course of treatment to determine its effectiveness and the appropriateness of the level of care and continued medical necessity. The HPCC clinician must authorize all extended lengths-of-stay and transfers to different levels of care as well as any related additional services.

Enrollee Reimbursement Provisions

HPCC has made arrangements with its contracted providers to ensure that all bills are submitted directly to HPCC for payment. However, if an enrollee receives any behavioral health treatment from a non-contract provider, the enrollee may receive a bill for such services. The Enrollee must provide HPCC with a copy of the bill or claim as soon as possible. Enrollees should mail claims to: **Holman Professional Counseling Centers, 9451 Corbin Ave., Suite 100, Northridge, California 91324.**

Provider Compensation Procedure

HPCC provider hospitals, acute care, sub-acute care, and transitional care facilities, are all paid on a discounted fee-for-service or fixed charge per day. HPCC does not use or permit any type of financial bonuses or incentives in its contracts with providers. If an enrollee wishes to know more about

reimbursement procedures, the Enrollee may request additional information from HPCC at **1-800-321-2843.**

Continuity of Care – Transition Assistance for New Enrollees

In order to provide transition with minimal disruption for enrollees who meet certain requirements to continue an active course of treatment with either a terminated provider or for new enrollees a non-participating provider a benefit transitional period. In the case of new enrollees, benefits will be provided at the new plan benefit level in this EOC. HPCC will make every effort to transition care for the employees who are utilizing a non-participating provider.

When a member has a need for care in an area that has a shortage of one or more types of providers, HPCC shall ensure timely access to covered health care services by referring enrollees to available and accessible contracted providers in neighboring areas consistent with patterns of practice for obtaining mental health care services in a timely manner appropriate for the member's needs. Also, in any such area where the plan's broad network has a pocket of no access for a member wanting to access services, the plan will immediately locate a suitable provider/facility and arrange a Letter of Agreement (LOA) with such provider/facility. Additionally, should the services being requested be above and beyond what a Letter of Agreement entails, the Plan will immediately recruit and fully contract with providers/facilities to provide services for the enrollee. This action will ensure that the member has appropriate access to care as well as guarantee that the member will only be responsible for their applicable co-payments, co-insurance and deductibles.

In order for a provider to continue treating HPCC enrollees during a transition period the provider must agree in writing to:

- **provide or continue to provide the employee's treatment and follow-up care;**
- **shall or continue to share information regarding the treatment plan with HPCC;**
- **accept or continue to accept HPCC rates/fee schedules; and in the case of a terminated provider to;**
- **continue to abide by the terms and conditions of the prior contract.**

Continuity of Care for Enrollees Receiving Services at the Time of a Provider Termination

At the request of an enrollee who is undergoing an acute or serious chronic condition at the time of a provider termination, HPCC will provide for the continuation of covered services for a limited time with that terminated provider, as long as provider's termination was not for medical or criminal disciplinary action. HPCC will furnish the enrollee with Behavioral Health Services from the terminated provider for up to ninety (90) days or a longer period if necessary for a safe transfer to another provider as determined by HPCC in consultation with the terminated provider, and consistent with good professional practice. To request continued care from a terminated Provider, the Enrollee must contact HPCC at **1-800-321-2843**. Continuity of care for enrollees whose provider has been terminated will be provided in general accordance with the applicable "Continuity of Care after Termination of Provider" section in your Anthem Blue Cross Plan Evidence of Coverage Booklet.

Coordination of Benefits

If an Enrollee receives behavioral health benefits under another behavioral health care plan, benefits provided by HPCC will be coordinated with the benefits from the other behavioral health care plan. This may result in HPCC not being responsible for payment of amounts, which are the responsibility of the other behavioral health care plan. HPCC will coordinate your deductible with your primary health plan. If you have additional questions, do not hesitate to contact a HPCC Representative at 1-

800-321-2843. Please see the applicable "Coordination of Benefits" section in your Anthem Blue Cross Plan Evidence Coverage Booklet for more information.

Charges for Missed Appointments (Contracted Providers Only)

An HPCC Contracted Provider will charge an enrollee the sum of thirty-five dollars ($35.00) for any missed appointment, except in the case where the contracted provider is notified at least twenty-four (24) hours in advance of the appointment that it will not be kept or the failure to keep the appointment was due to circumstances beyond the Enrollee's reasonable control.

Annual Benefit Maximum

Payments for HPCC authorized services are limited to the combined annual and lifetime maximums stated in the Benefits Schedule.

Liability of Enrollee for Payment for Pre-Authorized Services

CALIFORNIA LAW PROVIDES THAT ENROLLEES ARE NOT LIABLE FOR ANY AMOUNT OWED BY HPCC TO ANY CONTRACT PROVIDER IN THE EVENT HPCC DOES NOT PAY FOR PRE-AUTHORIZED SERVICES. Authorized treatment by a provider shall not be rescinded or modified after the provider renders the service in good faith pursuant to the authorization.

Second Medical Opinions.

An Enrollee or participating provider, who is treating an Enrollee, may request a second medical opinion by an appropriately Qualified Health Care Professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

- Reasonableness or necessity of recommended treatment is questioned;
- Diagnosis or treatment plan is questioned;
- Clinical indications are not clear or are complex and confusing;
- Treatment plan in progress is not improving the condition of the Enrollee within an appropriate period of time given the diagnosis and plan of care.

HPCC's decision to grant or deny the request for a second medical opinion will be delivered to the individual who requested the second medical opinion. In an emergency situation, the second opinion shall be rendered within seventy-two (72) hours after the receipt of the request. If the request for a second opinion is approved, the Enrollee will be responsible for all applicable co-payments. If the request for a second opinion is denied, the Enrollee will be notified in writing of the reasons for the denial and shall be informed of the right to file a grievance with the Plan. The request for a second medical opinion can be made by calling HPCC at **1-800-321-2843**, or by writing to: **Holman Professional Counseling Centers, Care Management Department, 9451 Corbin Ave., Suite 100, Northridge, California 91324.**

Renewal Provisions

The Group Plan Contract between AUHSD and HPCC is for a term of one year unless otherwise indicated. Unless terminated in one of the methods included in "Termination of Benefits," the Group Plan Contract will be renewed annually at such rates and upon such terms as may be agreed upon by HPCC and AUHSD at the time of renewal. AUHSD will notify Enrollees of any change to the Group Health Plan thirty (30) days prior to the effective date of change.

Termination of Benefits

Coverage and benefits for enrollee and enrollee's Eligible Dependents will end in the event of any of the following, except as provided for in the section, "Individual Continuation of Benefits." If your Employer fails to pay HPCC the appropriate premiums for you and/or your dependents, HPCC may terminate the benefits for you and/or your dependents if the Employer has been duly notified with the notice of cancellation and billed for the charge and at least a 30-day grace period has elapsed since the date of the receipt of the last premium payment. Coverage will continue during the grace period; however, the Employer will be still responsible to pay unpaid premiums and any copayments, coinsurance or deductible amounts required under the group plan contract. Grace period means a period of at least 30 days beginning no earlier than the first day after the last date of paid coverage to allow the Employer to pay an unpaid premium amount without losing healthcare coverage. At a minimum this grace period shall extend through the thirtieth (30^{th}) day after the last date of paid coverage.

If HPCC withdraws a health benefit plan from the market, HPCC will notify the Employer, enrollees and the director at least 90 days prior to the discontinuation of the group contract. Notice of the decision to cease new or existing health benefit plans in the state is provided to the director, the Employer and the enrollees covered under this group plan contract at least 180 days prior to the discontinuation of this contract.

In the case of this group plan contract, violation of a material contract provision relating to employer contribution or group participation rates by the contract holder or employer.

Should there be a nonpayment of premiums by the Employer to HPCC, HPCC will send the Employer a notice of consequences for nonpayment of premiums. Notice of consequences for nonpayment of premiums means notice sent by HPCC to the Employer that the Group Plan Contract will be cancelled, rescinded or not renewed unless the premium amount due is received by HPCC no later than the last day of the Grace Period. Your benefits will continue until the last day of the Grace Period.

Enrollee Termination for Non-Eligibility

An Enrollee's coverage may terminate for any of the following reasons:

- The Enrollee no longer meets the eligibility requirements established by AUHSD/ Anthem Blue Cross plan.

Ending Coverage – Special Circumstances for Enrolled Dependents

Eligible Dependents terminate on the same date of termination as the Enrollee. If there is a divorce, the spouse loses eligibility. Dependent children lose their eligibility if they marry or reach the limiting age established by AUHSD and do not qualify for extended coverage as a student dependent or as a disabled dependent.

Termination for Good Cause

HPCC has the right to terminate your coverage under this Plan in the following situations:

- **Failure to Pay.** Your coverage may be terminated for employer's nonpayment of required premiums owed to HPCC if your employer has been duly notified and billed for the charge and at least a 30-day grace period has elapsed since the date. of the receipt of the last premium payment.. Coverage will continue during the grace period; however, the Employer will be still responsible to pay unpaid premiums and any copayments, coinsurance or deductible amounts required under the group plan contract.

- **Fraud or Misrepresentation.** Your coverage may be terminated if you knowingly provide false information (or misrepresent a meaningful fact) in the enrollment process or fraudulently or deceptively use services or facilities of HPCC and/or it's Contracted Providers (or knowingly allow another person to do the same.) If coverage is terminated for the above reasons, you forfeit all rights to enroll in the COBRA Plan and lose the right to re-enroll with HPCC in the future.

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If coverage is terminated for good cause, you forfeit all rights to enroll in the COBRA Plan and lose the right to re-enroll with HPCC in the future.

Cancellation of AUHSD Contract

Continuing coverage under this Plan is subject to the terms and conditions of AUHSD's Group Contract with HPCC. If the Group Contract is cancelled, coverage for you and all your Eligible Dependents will end **after a written notice of termination of coverage is given and a 30-day grace period has elapsed since the date of the receipt of the last premium payment. Coverage will continue during the grace period**

If an Enrollee's eligibility is terminated for any of the above reasons, the Enrollee will be notified in writing and informed of the effective termination date. Coverage of the Enrollee's dependents will end when Enrollee's coverage ends. However, termination of a dependent's coverage only, will not affect the other enrolled family members. Any member who is undergoing treatment in a hospital at the time of cancellation will continue to be covered under the terms of the Agreement until discharge.

It is the responsibility of Employer to notify the enrollee of the termination of this group contract. In the event we provide notice of cancellation, within five business days, for non-payment of premium to the Employer, Employer agrees to promptly mail a legible, true copy of the notice of cancellation to all enrollee at their current address. The notice of cancellation will include:

- Effective date of the cancellation and grace period; the date of the last day of paid coverage
- The reason for cancellation, including reference to the applicable clause in this Agreement;
- The dollar amount due to the Plan
- The date the grace period begins and expires. Grace period means a period of at least 30 days beginning no earlier than the first day after the last date of paid coverage to allow the Employer to pay an unpaid premium amount without losing healthcare coverage. At a minimum this grace period shall extend through the thirtieth (30^{th}) day after the last date of paid coverage.
- The obligations of the enrollee or group contract holder during the grace period (if any)
- A statement that the cause for cancellation was not due to the enrollees health status or requirements for health services;
- That a enrollee who alleges that cancellation was due to the enrollees health status may request a review of cancellation by the Department of Managed Health Care;

Under no circumstances will an Enrollee be terminated due to health status or the need for services. Any Enrollee who believes his or her enrollment has been terminated due to health status or required services may request a review of the termination by the California Department of Managed Health Care.

Right to Request Review of Rescission, Cancellation, or Nonrenewal of Your Enrollment or **Subscription.**

If you believe that your health plan enrollment or subscription has been, or will be, improperly rescinded, canceled, or not renewed, you have the right to file a complaint. A complaint is also called a grievance or an appeal.

The DMHC oversees PPOs and other plans in California and protects the rights of PPO enrollees. You can file a complaint with the DMHC if:

- You are not satisfied with HPCC's decision about your complaint, or;
- You have not received the decision with 30 days, or within 3 days if the problem is urgent.
- The DMHC may allow you to submit a complaint directly to the DMHC, even if you have not PPOfiled a complaint with your health plan, if the DMHC determines that your problem requires immediate review.

An optional DMHC complaint form is available at www.healthhelp.ca.gov.

For help, contact:

Help Center, DMHC
980 Ninth St., Ste. 500
Sacramento, CA. 95814-2725
1-888-466-2219
TDD: 1-877-688-9891
Fax: 1-916-255-5241
www.healthhelp.ca.gov

There is no charge to call. Help is available in many languages.

Individual Continuation of Benefits: Federal COBRA Provisions

A member or member's dependents, **other than a domestic partner, and a child of a domestic partner**, may choose to continue coverage under the agreement if your coverage would otherwise end due to a Qualifying Event, listed below. For more information please refer to the applicable section "Keeping Anthem Blue Cross PPO After your Coverage Status Changes" in your Anthem Blue Cross Plan Evidence of Coverage Booklet for more information.

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 provides for the continuation of health insurance coverage for eligible enrollees and their dependents, of trusts with 20 and over eligible enrollees, for a defined period of time after certain qualifying events occur. Ordinarily, an Enrollee's benefits will cease when AUHSD's coverage terminates or under any other circumstance listed in "Termination of Benefits". However, in the case of certain qualifying events, a qualified Enrollee and Enrollee's Eligible Dependents may be able to continue group plan coverage under

federal COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) provisions for a limited time, if Enrollee agrees to pay the Premium for such coverage. A qualified enrollee is an enrollee, who on the day before a qualifying event, is an enrollee in a group benefit plan offered by a health care service plan, and who has a qualifying event. A qualifying event is limited to the following: death of covered Enrollee; termination of membership for reasons other than gross misconduct; divorce or legal separation of the covered Enrollee from the covered Enrollee's spouse; or loss of dependent status by a dependent enrolled in the Group Plan.

The qualified Enrollee shall, upon election, be able to continue his or her coverage under AUHSD's Group Plan Contract, subject to the Group Plan's terms and conditions, for a limited amount of time. The Enrollee must elect COBRA coverage by notifying AUHSD in writing within sixty (60) days of the date of the qualifying event. The written request must be delivered by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to AUHSD within the sixty (60) day period following the later of 1) the date that the Enrollee's coverage under the group plan contract terminated or will terminate by reason of a qualifying event, or 2) the date the Enrollee was sent notice of the ability to continue coverage under the Group Plan Contract. The failure to notify AUHSD within the required sixty (60) days will disqualify the qualified beneficiary from receiving continuation coverage under COBRA provisions. An Enrollee electing continuation shall pay to AUHSD in accordance with the terms and conditions of the group plan contract, the amount of the required Premium payment. The Enrollee's first Premium payment required to establish Premium payment shall be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to AUHSD within forty-five (45) days of the date the qualified beneficiary provided written notice to AUHSD, of the election to continue coverage, in order for coverage to be continued under COBRA provisions.

The first Premium payment must equal an amount sufficient to pay any required Premiums and all Premiums due, and failure to submit the correct Premium amount within the forty-five (45) day period will disqualify the Enrollee from receiving continuation coverage pursuant to COBRA provisions. Enrollees whose continuation coverage terminates under a prior Group Plan may continue their coverage for the balance of the period that the Enrollee would have remained covered under the prior Group Plan. Enrollees electing to continue coverage must notify AUHSD in writing and pay to AUHSD the required Premium payments. The continuations coverage will terminate if the Enrollee fails to comply with the requirements pertaining to enrollment in, and payment of Premiums to, the new Group Plan Contract within thirty (30) days of receiving notice of the termination of the prior group plan contract. A qualified enrollee can request Cal-Cobra at the conclusion of their Federal Cobra benefits explained below.

<u>Cal-Cobra Provisions (applicable only to California enrollees)</u>

For more information please refer to the applicable section "Keeping Anthem Blue Cross PPO After your Coverage Status Changes" in your Anthem Blue Cross Plan Evidence of Coverage Booklet."

The California Continuation Benefits Replacement Act (Cal-COBRA) provides that continued access to health insurance coverage is provided to enrollees, and their dependents, of Insurance trusts with 2 to 19 eligible members who are not currently offered continuation coverage under the federal COBRA, and those eligible enrollees who have exhausted their Federal COBRA benefits.

For a California qualified enrollee whose Cal-COBRA coverage begins on or after January 1, 2003, and who has exhausted continuation coverage under COBRA, the enrollee may extend their Cal-

COBRA coverage for up to 36 months after the date the qualified enrollee's benefits under a group plan health contract would otherwise have ended because of a qualifying event if the enrollee agrees to pay the Premium for such coverage. A qualified enrollee is an enrollee, who on the day before a qualifying event is an enrollee in a group benefit plan offered by a health care service plan, and who has a qualifying event. A Cal-COBRA qualifying event is limited to the following: death of covered enrollee, termination of membership for reasons other than gross misconduct; divorce or legal separation of the covered enrollee from the covered enrollee's spouse, or loss of dependent status by a dependent enrolled in the group plan.

The qualified enrollee must notify AUHSD within 60 days of the date of the qualifying event. Failure to make such notification within the required 60 days will disqualify the enrollee from receiving continuation coverage. A qualified enrollee who wishes to continue coverage under the group benefit plan must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to AUHSD within the 60-day period following the later of (1) the date that the enrollee's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the enrollee was sent notice of the ability to continue coverage under the group benefit plan.

A qualified beneficiary electing continuation shall pay to AUHSD the required Premium on or before the due date of each payment but not more frequently than on a monthly basis. The Premium will not be more than 110 percent of the applicable rate charged for a covered member or, in the case of dependent coverage, not more than 110 percent of the applicable rate charged to a similarly situated individual under the group benefit plan being continued under the group contract. In the case of a qualified beneficiary who is determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, the qualified beneficiary shall be required to pay to their trust an amount no greater than 150 percent of the group rate after the first 18 months of continuation coverage provided pursuant to this section.

The qualified enrollee's first Premium payment required to establish Premium payment shall be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to AUHSD within 45 days of the date the qualified enrollee provided written notice to AUHSD of the election to continue coverage. The first Premium payment must equal an amount sufficient to pay any required Premiums and all Premiums due, and failure to submit the correct Premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage. In the event the qualified enrollee does not receive information from AUHSD, i.e. Premium amount and due date, the qualified enrollee should contact HPCC using the contact information provided below.

Individuals not eligible for Cal-COBRA are those who: are entitled to Medicare benefits; have other hospital, medical, or surgical coverage; are eligible for federal COBRA; are eligible for coverage under Chapter 6A of the Public Health Service Act; fail to meet the specified time limits for electing coverage; and, fail to submit the correct premium amount required.

Enrollees whose continuation coverage terminates under a prior group plan may continue their coverage for the balance of the period that the enrollee would have remained covered under the prior group plan. Enrollees electing to continue coverage must notify AUHSD in writing and pay to AUHSD the required Premium payments. The continuations coverage will terminate if the enrollee fails to comply with the requirements pertaining to enrollment in, and payment of Premiums to, the

new group plan contract within thirty (30) days of receiving notice of the termination of the prior group plan contract.

For more information on how to extend their COBRA coverage, the enrollee should contact Lisa Solomon by phone at 1-800-321-2843, or in writing at Holman Professional Counseling Centers, 9451 Corbin Ave., Suite 100. Northridge, CA 91324.

EXCLUSIONS

1. Late Cancel/No-Show Penalty. Except in those cases where the enrollee notifies the Contracted/In-Network Provider at least twenty-four (24) hours in advance that the scheduled session will not be kept or the failure to keep the appointment was due to circumstances beyond the Enrollee's reasonable control, the Enrollee will be charged the sum of thirty-five dollars ($35.00) directly by the Contracted Provider for scheduled sessions that are **not** kept.

2. Services provided by Non-Contracted Providers except for those that qualify as emergency behavioral health treatment hospital admissions or otherwise authorized by HPCC are not a covered benefit.

3. Treatments which do not meet national standards for behavioral health professional practice are not a covered benefit.

4. Treatment sessions provided by computer Internet services are not a covered benefit, unless specifically pre-authorized.

5. Court ordered inpatient and outpatient treatment is covered only when Medically Necessary. Reporting to the court and interacting with the court are not covered services under this Agreement.

6. Academic or educational testing; services to remedy an academic or educational problem are not a covered benefit.

7. Psychotherapy used as professional training and not for the treatment of a medical or mental condition is not a covered benefit.

8. Use of sexual surrogate, sexual treatment of sexual offenders or perpetrators of sexual violence are not a covered benefit. Reporting to the court and interacting with the court are not covered services under this Agreement.

9. Counseling by an unlicensed, non-contracted provider will not be covered under this benefit plan.

10. All non-prescription and prescription drugs prescribed in connection with an enrollee's treatment are not a covered benefit.

11. Therapy specifically for the sole purpose of consciousness raising.

12. Surgery, acupuncture, physical therapy, or occupational therapy are not covered benefits.

13. Neurological services and tests, including but not limited to: EEGs, Pet scans, beam scans, MRIs, skull X-rays, and lumbar punctures are not covered benefits.

14. Work, career, employment, or professional related evaluations, treatments, or counseling for non-medical purposes are NOT covered benefits.

15. Acute care hospital benefit is limited to emergency services only. Emergency services include all hospital treatment and hospital ancillary services necessary to stabilize an emergent condition. Authorization is not required for emergencies.

16. Bio-feedback & Neuro-feedback must be specifically preauthorized.

17. Anorexia nervosa and Bulimia nervosa is limited to the psychological factors and disturbances in eating disorders. Medical conditions resulting from eating disorders are not a covered benefit.

18. Any service that is not Medically Necessary even though it is not specifically listed as an exclusion or limitation.

19. Any service that is not specifically listed as a covered benefit.

20. HPCC is the decider of Medical Necessity subject to the DMHC review process.

21. Behavioral Health Treatment used for purposes of providing or for the reimbursement of respite, day care, or educational services or to reimburse a parent for participating in the treatment program are not covered benefits.

ENROLLEE GRIEVANCE PROCESS

FILING GRIEVANCES: All Enrollees will have reasonable access to the filing of a complaint. Enrollees shall have up to 180 calendar days following any incident or action that is the subject of the enrollee's dissatisfaction to file a grievance with HPCC. Complaints may be reported to any HPCC staff member in person, or by telephone by calling (800) 321-2843. Also, complaints may be submitted in writing to Holman Professional Counseling Centers, 9451 Corbin Ave., Suite 100, Northridge, CA 91324, or via the Plan's secure website at www.Holmnagroup.com. A HPCC staff member will then immediately direct the complaint to the Compliance Specialist. The Plan's address, telephone number and procedures for initiating complaints are communicated in the Enrollee benefit book. Grievance Complaint forms are also available from all Plan Providers (Grievance Complaint Forms are included in the initial packet of documents provided to contracted providers). In addition, grievance forms are placed on HPCC's website. Additionally, providers are sent a mailing notification informing them that the grievance forms in their packets should be copied and made available to enrollees upon request or when indicated (via concerns voiced) by the enrollee. Grievance Forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan's website, and from each contracting provider's office or facility. Grievance forms shall be provided promptly upon request. Enrollees will be updated of any revisions to the grievance process-whether it be by sending the updated grievance policy and/or Evidence of Coverage detailing the changes in the grievance policy. HPCC shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance.

Resolution of Grievance: Grievances will be directed to the Compliance Specialist. The Compliance Specialist will work together with the Enrollee to resolve the issue if possible. All grievances will be referred to the Grievance Committee, unless the grievance is resolved within 24 hours and/or the enrollee declines the grievance process. HPCC will mail out to the enrollee a written acknowledgement of receipt of the grievance within five (5) calendar days (Acknowledgement Letter). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the HPCC representative, telephone number and address of the HPCC representative who may be contacted about the grievance. The enrollee will be advised when the committee will be meeting regarding their grievance and include a brief description of their grievance in the letter. The Grievance Committee will review the grievance and within thirty (30) days from HPCC's receipt of the grievance, HPCC will send a written notice of the resolution. If the grievance is denied, the notice will explain why the grievance was denied and how the Enrollee may appeal the decision of the Grievance Committee. An Enrollee may submit a grievance to the Department of Managed Health Care for review, after completing HPCC's grievance process or after having participated in HPCC's grievance system for thirty (30) calendar days. Mail grievances to: **HPCC, 9451 Corbin Ave., Suite 100, Northridge, California, 91324**

Arbitration*: If the Enrollee remains dissatisfied with the decision, the Enrollee may submit a request to HPCC to submit the grievance to binding Arbitration before the American Arbitration Association. Pursuant to California law a single neutral arbitrator who shall be chosen by the parties and who shall have no jurisdiction to award more than $200,000 must decide any claim of up to $200,000. However, after a request for arbitration has been submitted, HPCC and the Enrollee may agree in writing to waive the requirement to use a single arbitrator and instead use a tripartite arbitration panel that includes the two party-appointed arbitrators or a panel of three neutral arbitrators or another multiple arbitrator system mutually agreeable to the parties. The Enrollee shall have three (3) business days to rescind the waiver agreement unless the agreement has also been signed by the Enrollee's attorney, in which case the waiver cannot be rescinded. In cases of extreme hardship, HPCC may assume all or part of the Enrollee's share of the fees and expenses of the neutral arbitrator provided the Enrollee has submitted a hardship application with the American Arbitration Association. The American Arbitration Association shall determine the approval or denial of a hardship application. A hardship application may be obtained by contacting the American Arbitration Association in Los Angeles at 213-383-6516, in Orange County at 714-474-5090, in San Diego at 619-239-3051 and in San Francisco at 415-981-3901.*

If the Enrollee does not request arbitration within six months from the date of the Grievance Resolution Notice, the decision of the Committee shall be final and binding. However, if the Enrollee has legitimate health or other reasons which would prevent them from electing binding arbitration in a timely manner, the Enrollee will have as long as necessary to accommodate his or her special needs in order to elect binding arbitration. Further, if the Enrollee seeks review by the Department of Managed Health Care, the Enrollee will have an additional ninety (90) days from the date of the final resolution of the matter by the Department of Managed Health Care to elect binding arbitration. Upon submission of a dispute to the American Arbitration Association, both the Enrollee and HPCC agree to be bound by the rules of procedure and decision of the American Arbitration Association.

Full discovery shall be permitted in preparation for arbitration pursuant to California Code of Civil Procedure, Section 1285.05.

California Health and Safety Code Section 1361.1 requires that any arbitration agreement include the following notice based on California Code of Civil Procedures 1295(a): It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently

rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

If your coverage is provided under an employer sponsored plan subject to ERISA, certain disputes may not be subject to the Binding Arbitration provision found herewith.

Expedited Grievance Review: For cases involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, HPCC provides expedited review. When HPCC has notice of a case requiring expedited review, HPCC shall immediately inform the enrollee in writing of their right to notify the Department of Managed Health Care of the request. For these cases, HPCC will provide the Enrollee and the Department with a written statement on the disposition or pending status of the request no later than three (3) days from receipt.

Treatment Denials: If a Provider or Enrollee notifies HPCC of a dissatisfaction regarding a treatment authorization denial, it will be directed to the assigned staff. HPCC will work together with the Provider and/or Enrollee to resolve the complaint. Within thirty (30) days from HPCC's receipt of the complaint, HPCC will send the Provider and/or Enrollee a written notice of the resolution. If the Provider or Enrollee's complaint is denied, the notice will explain how the Provider or Enrollee may appeal the decision.

Treatment Denial Appeals: If the Provider/Enrollee is dissatisfied with HPCC's resolution of the treatment denial, the Provider/Enrollee may file an Appeal by notifying HPCC of his/her dissatisfaction. The Appeal will be determined by a HPCC staff psychiatrist for inpatient care or by the HPCC doctoral level staff practitioner for outpatient care. Written notice of the Appeal Committee's decision will be sent to the Provider/Enrollee within thirty (30) days of receipt of the appeal notice.

Expedited reviews of treatment denials are available to Providers and/or Enrollees. In these cases, HPCC will provide verbal resolution within eight (8) business hours of HPCC's receipt of necessary information to make an informed decision and in writing within two (2) days of receipt.

California Department of Managed Health Care: The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against HPCC, you should first telephone HPCC at **(1-800-321-2843)** and use HPCC grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by HPCC, or a grievance that has remained unresolved for more than thirty (30) days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by HPCC related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-PPO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online. HPCC also has these forms available and will furnish them as appropriate and required.

An Enrollee, or the agent acting on behalf of the Enrollee, may also request voluntary mediation with the Plan prior to exercising the right to submit a grievance to the Department. The use of mediation services shall not preclude the right to submit a grievance to the Department upon completion of mediation. In order to initiate mediation, an Enrollee, or the agent acting on behalf of the Enrollee, and the Plan shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The Department shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

Claims Disclosure Notice Required By ERISA: If this plan is subject to ERISA, ERISA applies some additional claim procedure rules. For these additional rules set forth by ERISA, see applicable section in Anthem Blue Cross Plan Evidence of Coverage booklet entitled "Claims Disclosure Notice Required by ERISA."

HPCC's Public Policy Committee: HPCC operates a Public Policy Committee that is mandated to maintain professional standards. It functions as an open forum to provide Enrollees with an opportunity to discuss prevailing societal issues, difficulties with current policies, and additional available services. The purpose of the Public Policy Committee is to ensure the comfort, dignity, and convenience of persons relying upon HPCC for behavioral health care services. In order to assure Enrollee participation in Plan policy, the Public Policy Committee shall consist of the following members: HPCC Vice President of Sales & Client Services staff and a minimum of three current Enrollees. The Vice President of Sales & Client Services selects the Enrollee members of the Public Policy Committee. Any Enrollee interested in the Public Policy Committee may direct their request in writing to: **HPCC, 9451 Corbin Ave., Suite 100, Northridge, California, 91324.**

Language Assistance Program ("LAP"):
The Department of Managed Health Care ("DMHC") of California added Section 1300.67.04 (Language Assistance Programs) to Title 28 California Code of Regulations. This regulation requires health care service Plans to implement policies, procedures and quality improvement efforts in regards to assisting those who are Limited English Proficient ("LEP"). The DMHC regulations require California health Plans to set up a system where services, materials, and information are provided to members in a language that they speak and understand.

In accordance with the DMHC regulations, the Plan has identified its threshold language(s) which comprise five (5) percent of its Enrollee Population. All vital documents, as identified by the DMHC, will be translated into the threshold language. All non-vital documents will contain a notice at the bottom of said document (in the threshold language(s)) informing the member how to request a translation of the document.

The Plan has established a free Language Assistance Program and made the following resources available for LEP individuals: Translations (in the threshold languages), Interpreters, and Bilingual staff/Providers. These resources are available for all persons who request these services at any of our points of contact.

Antifraud Policy and Procedures:
HPCC makes every effort to detect, investigate, and prosecute any incidents of fraud at any level within its behavioral health care service. Fraud hurts everyone through higher taxes to fund government health care plans and higher premiums for private health coverage. In order to insure that our Enrollees do not have to pay for the high cost of fraud, we encourage you to report fake claim schemes. We are here to help you recognize and report any incidents or suspected incidents of fraud you discover. If you notice that a claim submitted to HPCC by your Provider's office includes a charge for a therapy session you did not receive, you may have detected health care fraud. The first

step is to notify your Provider of the incorrect charge. The second step is to notify HPCC at **1-800-321-2843.** HPCC wants your help to identify potentially fraudulent or abusive claim activities. If you know or suspect illegal or wrongful billing practices by a Provider or an Enrollee, please tell us. We will treat any information you provide with strict confidentiality. We promise not to disclose your identity unless you are willing to voluntarily give us your written permission. Furthermore, state and federal laws protect the confidentiality of your medical records. We will not release any medical information without lawful authorization.

HPCC contracts with a special investigator trained in fraud investigation to assist us in investigating fraud. In the event that HPCC detects any fraudulent activity on the part of a Provider, the Provider's contract with HPCC will be terminated. If HPCC detects any fraudulent activity on the part of an Enrollee, HPCC will deny Enrollee any additional benefits under Enrollee's Group Health Plan. Additionally, HPCC will prosecute fraud to the fullest extent of the law. We also cooperate with all government agencies in a combined effort to prevent and prosecute fraud on the part of both Providers and Enrollees.

Organ and Tissue Donation.

Approximately 77,000 people in the U.S. are on the national waiting list for an organ. An average of 15 people die every day because not enough organs are available. Organ and tissue transplantation saves lives. For example, about 60 people receive life-enhancing organ transplants each day and about 82% of patients who receive a donated kidney are still alive 5 years later.

For more information on how to become an organ and tissue donor, visit the U.S. Department of Health and Human Services web site at www.organdonor.gov or call: 1-888-ASK-HRSA (1-888-275-4772.).

BENEFIT SCHEDULE

PRINCIPAL BENEFITS AND COVERAGES

PPO Member Plan

AUHSD
MENTAL HEALTH & SUBSTANCE USE BENEFIT

MENTAL HEALTH/SUBSTANCE USE	IN-NETWORK	OUT-OF-NETWORK [4]
Deductible	$275/person & $1,100/family	
Out of Pocket Maximum [1, 2, 3]	$1,475 per individual per calendar year	$5,075 per individual per calendar year
3 EAP	$0 copay	N/A
Outpatient	10% coinsurance	40% coinsurance of covered expenses
Sub-acute (Residential) [1]	10% coinsurance	40% coinsurance of covered expenses
Inpatient Hospital	10% coinsurance	40% coinsurance (Is 10% coinsurance the first 48 hours; 40% coinsurance after 48 hours, unless the member can't be moved safely) **Emergency Only**

1. Required that member call in to HPCC to determine medically necessary care, to maximize benefits, subject to DMHC guidelines.
2. Any co-payments made for the treatment of mental and nervous disorder or substance use will be applied toward satisfying the out of pocket maximum.
3. After $2,000 per individual and $4,000 per family, in out of pocket payments for covered expenses, for participating providers, 100% of covered expenses are paid.
   HPCC uses RBRVS (professional) and DRGs (hospital), to calculate reimbursement for Non-contracted providers. **Any disputes are to be negotiated directly with HPCC. Every effort will be made to ensure that enrollees of HPCC are not subject to balance billing practices for covered services.**
4. RBRVs and DRGs are government approved reimbursement calculations for the reasonable and customary value of healthcare services rendered. They are based upon statistically credible information that is updated annually and takes into consideration:

a. The provider's training, qualifications and length of time in practice
b. The nature of services provided
c. The fees usually charged by the provider
d. Prevailing providers rates charged in general geographic areas in which services were rendered
e. Other aspects of the economics of the medical provider's proactive that are relevant and any unusual circumstances

Reimbursement of Non-Contracted Providers. UMC approved Non-Contracted Providers must submit their bills within 180 days of service being rendered in order to be considered eligible for payment. Bills must outline all services provided on a daily basis. Bills may be mailed to: Professional Counseling Centers, 9451 Corbin Ave., Ste. 100, Northridge, CA. 91324

Assumption of Risk/Liability

The enrollee may be liable to the non-contracted provider for the cost of services if services provided by the non-contracted providers are not previously approved by HPCC (unless it is a condition requiring emergency care which does not require Prior Authorization).

Notice to Enrollees:

Federal law requires all employer benefit plan administrators to furnish each enrollee receiving benefits under the plan, a copy of a summary plan description. **This summary plan description constitutes only a brief overview of the provisions of the Group Plan Contract that has been entered into between AUHSD and HPCC.** The Group Plan Contract must be consulted to determine the exact provisions of the Group Plan Contract. Depending upon whom you contact, The HPCC or AUHSD, will present a copy of the Group Plan Contract to you upon request.