(PacifiCare Behavioral Health logo)
Helping you navigate life's challenges

Benefit Program Summary

LANS

Definity Health

This is a summary of highlights of the above named Benefit Program, a component of the LANS Welfare Benefit Plan for Employees, ERISA Plan 501 ("Plan"). Receipt of this document and/or your participation in a Plan and any benefit programs under a Plan do not guarantee your employment or any rights or benefits under a Plan. LANS reserves the right to amend or terminate the Plan or any benefit program(s) under the Plan at any time. The Plan and the benefit programs referred to in this summary are governed by a Federal law (known as ERISA), which provides rights and protections to Plan participants and beneficiaries.

For more information on LANS benefit programs, see the LANS Welfare Benefit Plan for Employees Summary Plan Description available from the Los Alamos National Laboratory (LANL) Benefits Office at (877) 667-1806 or (505) 667-1806.

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INTRODUCTION

This *Benefit Program Summary* describes the terms and conditions of coverage under your Behavioral Health Benefit Program ("Benefit Program "). Read this document carefully in order to understand your Coverage under this Benefit Program . If you have any questions regarding your Coverage or procedures for obtaining Behavioral Health Services, you may call PacifiCare Behavioral Health, Inc. ("PBHI") at 1-800-817-8811. PBHI has entered into an agreement with LANS ("Plan Sponsor") to provide certain administrative services related to Coverage under this Benefit Program , including but not limited to premium billing and collection, claims payment, case management, pre-authorization and provider access.

All Behavioral Health Services, other than Emergency Treatment and Urgently Needed Services, are subject to prior authorization by PBHI, as described in this *Benefit Program Summary*.

Only Medically Necessary Behavioral Health Services are covered under this Benefit Program . PBHI has sole and exclusive discretion in interpreting the benefits covered under this Benefit Program and the other terms, conditions, limitations and exclusions set out in the *Administrative Services Agreement* and this *Benefit Program Summary.* In addition to the information contained in this *Benefit Program Summary*, the LANS Welfare Benefit Plan for Employees Summary Plan Description contains important information about your LANS welfare benefits. This Benefit Program is a part of the LANS Summary Plan Description ("SPD"). The LANS SPD is referred to in this *Benefit Program Summary* as "your LANS SPD". We encourage you to review this PacifiCare *Benefit Program Summary* carefully. You should also carefully read your LANS SPD.

For additional information:

Los Alamos National Laboratory (LANL)
LANL Benefits Office
P.O. Box 1663, Mail Stop P280
Los Alamos, NM 87544
(877) 667-1806 or (505) 667-1806
e-mail: **benefits@lanl.gov**
LANL Benefits Website for Employees: **http://int.lanl.gov/worklife/benefits/**

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

Or visit the PBHC website: www.pbhi.com

Customer Service
1-800-817-8811
1-888-877-5378 (TDHI)

SCHEDULE OF BEHAVIORAL HEALTH BENEFITS

LANS

Definity Health
Select EPO Schedule of Benefits

The Calendar Year Deductible, benefits maximums, benefit level, and lifetime maximums are combined for a member who transfers between the United Healthcare Plans.

	Benefits
Mental Health Services	
Maximum Inpatient Benefit, Per Member Per Lifetime	None
Inpatient, Residential and Day Treatment	Based on Medical Necessity
Coverage Level	100%
Calendar Year Deductible	None
Outpatient Treatment	Based on Medical Necessity
Copayment	$15.00 per visit
Chemical Dependency Rehabilitation	
Maximum Inpatient Benefit, Per Member Per Lifetime (Combined with Chemical Detoxification)	130 days[1]
Calendar Year Maximum Benefit	$10,000
Inpatient, Residential and Day Treatment (Combined with Chemical Detoxification)	1 treatment episode per Calendar Year[2]
Days to be determined based on the following levels of care	
Inpatient	1 day
Residential Treatment	7/10 of 1 day
Day Treatment	6/10 of 1 day
Calendar Year Deductible Amount (Waived for detoxification and outpatient treatment)	$250
Coverage Level	80%
Non-Compliance Reduction (Percentage by which a Member's coverage level is reduced when Member leaves the Chemical Dependency Inpatient, Residential Treatment or Day Treatment program against the medical advice of a PBHI Participating Provider)	30%
Chemical Detoxification	
Maximum Inpatient Benefit, Per Member Per Lifetime (Combined with Chemical Dependency)	130 days[1]
Calendar Year Maximum Benefit	$10,000
Maximum Benefit, Per Member, Per Calendar Year (Combined with Chemical Dependency)	1 treatment episode per Calendar Year[2]

Calendar Year Deductible Amount	None
Coverage Level	80%

All Mental Health, Chemical Dependency, and Detoxification treatment must be Pre-Authorized by PBHI toll free at 1-800-817-8877. The number of visits, days or episodes authorized must be Medically Necessary.

[1] For purposes of determining the number of treatment days for the maximum Inpatient benefit, Residential Treatment days are counted as 70 percent of one day and Day Treatment days are counted as 60 percent of one day. This permits the Member to obtain additional coverage when alternate levels of care are utilized. Number of days are determined by clinical appropriateness under the Benefit Program 's guidelines for Medical Necessity.

[2] Length of treatment episode(s) is (are) determined by clinical appropriateness under the Benefit Program 's guidelines for Medical Necessity.

Eligibility

The following individuals are eligible to enroll in this Benefit Program . If the Benefit Program is a Health Maintenance Organization (HMO), Point of Service (POS) or Exclusive Provider Organization (EPO) Plan, they are only eligible to enroll in the Benefit Program if they meet the Benefit Program 's geographic service area criteria. Anyone enrolled in a non-LANS Medicare Advantage Managed Care contract or enrolled in a non-LANS Medicare Part D Prescription Drug Plan will be deenrolled from this health Benefit Program .

Subscriber

Employee: You are eligible for participation if you meet the eligibility criteria as described in your LANS SPD.

Eligible Dependents (Family Members): When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined in your LANS SPD.

Other Eligible Dependents (Family Members): You may enroll a domestic partner (and the domestic partner's children/grandchildren/stepchildren) as set forth in your LANS SPD.

No Dual Coverage

Benefit Program rules do not allow duplicate coverage. See your LANS SPD for more information.

Additional information about eligibility and enrollment is available from the LANL Benefits Office (Employees).

Enrollment

Information about Enrollment can be found in your LANS SPD.

During a Period of Initial Eligibility (PIE)

Information about PIE can be found in your LANS SPD.

At Other Times

Information about other opportunities to enroll can be found in your LANS SPD.

Change in Coverage

Information can be found in your LANS SPD.

Effect of Medicare on Enrollment

Information can be found in your LANS SPD.

Medicare Secondary Payer Law (MSP)

Information can be found in your LANS SPD.

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services **(that would otherwise be covered by Medicare)** from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners. These private agreements will require the beneficiary to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or this Benefit Program , the Medicare limiting charge will not apply.

Some physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Benefit Program , and the Medicare limiting charge will not apply.

If you or a Family Member have Medicare as a primary coverage, are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by this Benefit Program for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Benefit Program to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see **other** providers who have not opted out of Medicare and receive the benefits of this Benefit Program for those services.

Benefits and Conditions for Coverage

Subject to all terms, conditions, exclusions, and limitations set forth in this Benefit Program , all eligible Members shall be entitled to the Behavioral Health Services and benefits described in this Benefit Program .

Member Obligations

Member shall submit to PBHI for reimbursement any and all claims for Emergency Services and Urgently Needed Services received for covered Behavioral Health Services from a non-participating

provider within ninety (90) days of the date of service if possible and in no event later than one (1) year from the date services are provided.
Pre-Authorization for Behavioral Health Services – Except for Emergency Treatment and Urgently Needed Services, all Behavioral Health Services received by a Member must be pre-authorized by a PBHI Clinician in order to qualify for coverage under this Benefit Program . Members requiring Behavioral Health Services must call PBHI's 24-hour phone number identified herein to arrange for an appointment with a PBHI Clinician.

A PBHI Clinician will evaluate the nature and severity of the Member's problem for Medical Necessity. If treatment is determined Medically Necessary, the PBHI Clinician will recommend the most appropriate treatment for Member. The PBHI Clinician will contact the Participating Facility or Participating Practitioner regarding the initially authorized Behavioral Health Treatment Program. The PBHI Clinician will only authorize services, which are Medically Necessary for the treatment of Mental Disorders or Chemical Dependency. No benefits are paid for services provided without the prior authorization of the PBHI Clinician, unless such services are Urgently Needed or required because of an Emergency.

Eligibility for In-Area Benefit – The in-area status of the primary subscriber (employee, retiree, or survivor) determines whether the employee/retiree/survivor and dependent receive in-area behavioral health benefits. However, in-area members who live or travel outside the United States receive emergency PBHI benefits only.

Concurrent Review of Behavioral Health Services – Member shall cooperate with PBHI's concurrent reviews of Behavioral Health Services which shall be conducted on a regular basis throughout a Member's Behavioral Health Treatment Program to ensure the effectiveness and appropriateness of the level of care, and to determine the necessity of a continuous stay and/or treatment. The PBHI Clinician must authorize all extended lengths of stay and transfers to different levels of care as well as any related additional services.

Reduction in Benefits for Failure to Complete an Inpatient Treatment Program – In order to receive the maximum benefits under this Benefit Program for a specific Chemical Dependency Inpatient Treatment Program, the Member must complete the entire Chemical Dependency Inpatient Treatment Program. If Member abandons a Chemical Dependency Inpatient Treatment Program prior to the scheduled discharge or transfer authorized by the PBHI Clinician, coverage for the Chemical Dependency Inpatient Treatment Program under this Benefit Program shall be reduced by thirty percent (30%). Member shall be required to reimburse the Participating Practitioner or Participating Facility for this Copayment.

Copayments – Copayments, when applicable, are an obligation of the Member at the time services are rendered. Failure to pay a Copayment may result in termination of Member's Coverage under this Benefit Program .
A schedule of the applicable Copayments for services rendered to Member is set forth in the *Schedule of Behavioral Health Benefits*.

Payment for Non-Covered Services – Nothing in this Benefit Program shall prevent the Benefit Program or the Participating Practitioner from collecting Prevailing Rates from the Member for non-covered services or for services rendered due to fraud or misrepresentation by

Emergency Treatment and Urgently Needed Services – The cost of an Emergency Treatment and Urgently Needed Services shall be covered by this Benefit Program if the following procedures are followed.

Procedure for Emergency Treatment and Urgently Needed Services

- If Member or someone acting on Member's behalf is unable to contact PBHI prior to going to a Facility for an Emergency Admission and Urgently Needed Services, Member or the person(s) acting on Member's behalf must notify or take reasonable steps to notify PBHI within twenty-four (24) hours or as soon as reasonably possible after the Emergency Treatment and Urgently Needed Services to inform PBHI of the location, duration and nature of the Emergency Treatment or Urgently Needed Services.

- If an Emergency Treatment or Urgently Needed Services are rendered at a Facility not designated by PBHI, Member or Member's representative should notify PBHI in writing as soon as possible of the nature and necessity of the Emergency Treatment and Urgently Needed Services and should attach any bills Member has received. Undisputed claims for Emergency Treatment and Urgently Needed Services shall be paid within thirty (30) working days of receipt of a properly completed claim.

  Mail notification and bills to:

  PacifiCare Behavioral Health, Inc.
  Claims Department
  P.O. Box 31053
  Laguna Hills, CA 92654-1054

- Facility admissions for non-emergency or non-Urgently Needed Behavioral Health Services which have not been authorized by PBHI and visits to non-Participating Practitioner for non-emergency or non-Urgently Needed Behavioral Health Services which have not been authorized by PBHI are not covered under this Benefit Program .

Continuing or Follow-Up Treatment – Continuing or follow-up treatment to an Emergency Treatment or for non-Urgently Needed Services must be coordinated through PBHI. PBHI will require the Member to transfer to a Participating Practitioner or Facility designated by PBHI, provided the transfer does not create an unreasonable risk to the Member's health.

Acts Beyond the Control of the Plan Sponsor or PBHI

In the event of circumstances not reasonably within the control of the Plan Sponsor or PBHI, such as any major disaster, epidemic, complete or partial destruction of Facility, war, riot, or civil insurrection, which results in the unavailability of the Facilities, personnel or Participating Practitioners, the Plan Sponsor, PBHI, Participating Practitioner and Participating Facilities shall provide or attempt to arrange

for Behavioral Health Services insofar as practical, according to their best judgment, with the limitation of such Facilities and personnel. Neither the Plan Sponsor nor PBHI nor any Participating Practitioner or Participating Facility shall have any liability or obligation for delay or failure to provide or arrange for Behavioral Health Services if such delay or failure is the result of any of the circumstances described above.

Questions and Complaints

Our first priority is to meet your needs and that means providing responsive service. If you ever have a question or problem, your first step is to call the PBHI Customer Service Department at 1-800-817-8811 for a resolution.

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

PacifiCare Behavioral Health, Inc.
Post Office Box 55307
Sherman Oaks, CA 91413-0307
Attn: Appeals Department
Or at the PBHI website: www.pbhi.com

When a complaint is received either by telephone or in writing by a PBHI Member Service Associate, the following procedure will be followed in handling complaints under the Appeal Procedure:

The PBHI Member Service Associate shall document the complaint (received either by telephone or in writing), the date received and the name of the PBHI Member Service Associate recording the complaint. If the complaint is by telephone and the person taking the call is unable to resolve the problem to the Member's satisfaction, the Member will be asked to submit a written complaint. The PBHI Member Service Associate will assist the Member in filing a written complaint if the Member desires the assistance.

Claims and Appeals Process

Information about ERISA claim and appeal procedures can be found in your LANS SPD.

Voluntary Binding Arbitration

If the Member is dissatisfied with the appeal, the Member may submit or request that PBHI submit the appeal to voluntary binding arbitration before Judicial Arbitration and Mediation Service ("JAMS").

Any and all disputes of any kind whatsoever, including, claims for medical malpractice (that is as to whether any medical services rendered under the health Benefit Program were unnecessary or unauthorized or were improperly, negligent, or incompetently rendered), except for claims subject to

ERISA, between Member (including any heirs, successor or assigns of Member) and PBHI, or any of its parents, subsidiaries or affiliates may be submitted to voluntary binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. Member and PBHI are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of voluntary binding arbitration by a single arbitrator in accordance with the Comprehensive Arbitration Rules and Procedures of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor mutually to agree to the appointment of the arbitrator; but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Arbitration Rules and Procedures will be utilized.

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

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

BY ENROLLING IN PACIFICARE BEHAVIORAL HEALTH (PBHI) BOTH MEMBER (INCLUDING ANY HEIRS, SUCCESSOR OR ASSIGNS OF MEMBER) AND PBHI MAY AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO A JURY TRIAL AND INSTEAD VOLUNTARILY AGREE TO THE USE OF BINDING ARBITRATION AS DESCRIBED IN THIS *BENEFIT PROGRAM SUMMARY*

Quality Review Process

The Quality review process is an internal review process that addresses concerns regarding the quality or appropriateness of services by Participating Providers that has the potential for an adverse effect on the Member. Upon receipt of the concern, referral is made to the Quality Improvement Department for investigation.

Quality of care complaints that affect current treatment shall be immediately evaluated and, if necessary, other appropriate Administrator personnel and the Participating Provider will be consulted. The relevant medical records will be obtained and reviewed and appropriate action taken.

If a written complaint has been submitted, the Member shall be notified of the completion of the review in writing within thirty (30) days. The oral and written communications involving the Quality Review Process and the results of the review shall remain confidential.

Member Claims Against Participating Practitioners and Facilities

Member acknowledges that Participating Practitioners and Participating Facilities are independent contractors and that the Benefit Program does not assume responsibility for the acts of the Participating Practitioners and Participating Facilities as the result of this independent contractor relationship.

Member claims for damages as the result of an injury caused or alleged to have been caused by an act or failure to act by Participating Practitioner, Participating Facility or other provider of Behavioral Health Services are not governed by this Benefit Program . Member may seek any appropriate legal action against such persons and entities deemed necessary.

Termination of Coverage

The termination of coverage provisions that are established by LANS are described in your LANS SPD.

Deenrollment Due to Loss of Eligible Status

Information can be found in your LANS SPD.

Deenrollment Due to Fraud

Information can be found in your LANS SPD

Leave of Absence, Layoff or Retirement

Information can be found in your LANS SPD.

Optional Continuation of Coverage

Information can be found in your LANS SPD.

PBHI Nonliability After Termination

PBHI shall have no further liability to provide benefits to any Member, including, without limitation, those Members who are inpatient in a Facility or are undergoing treatment for an ongoing condition after termination of this Benefit Program . Member’s right to receive benefits hereunder shall cease upon the effective date of termination of this Benefit Program .

Third Party Liability

In the case of injuries caused by any act or omission of a third party, and any complications incident thereto, the benefits of this Benefit Program shall be furnished to a Member. Member agrees, however, to reimburse this Benefit Program , or its nominee, for the cost of all such benefits provided, at Prevailing Rates, immediately upon obtaining a monetary recovery, whether due to settlement or judgment, on account of such injury. Member shall hold any such sum in trust for this Benefit Program , but said sum shall not exceed the lesser of, the amount of the recovery obtained by Member or the reasonable value of all such benefits furnished to the Member or on a Member's behalf by this Benefit Program on account of such incident.

Member agrees that this Benefit Program 's rights to reimbursement are the first priority claim against any third party. This means that this Benefit Program shall be reimbursed from any recovery before payment of any other existing claims, including any claim by the Member for general damages. This Benefit Program may collect from the proceeds of any settlement or judgment recovered by the Member or his or her legal representative regardless of whether the Member has been fully compensated.

Member agrees to cooperate in protecting the interest of this Benefit Program under this provision. Member must execute and deliver to PBHI any and all liens, assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the right of this Benefit Program , including, but not limited to, the granting of a lien right in any claim or action made or filed on behalf of Member and the signing of documents evidencing same.

Member shall not settle any claim, or release any person from liability, without the written consent of PBHI, wherein such release or settlement will extinguish or act as a bar to this Benefit Program 's rights of reimbursement.

In the event PBHI employs an attorney for the purpose of enforcing any part of this Section against a Member based on Member's failure to cooperate with PBHI, the prevailing party in any legal action or proceeding shall be entitled to reasonable attorney's fees.

In lieu of payment as indicated above, PBHI, at its option may choose that this Benefit Program be subrogated to the Member's rights to the extent of the benefits received under this Benefit Program . This Benefit Program 's subrogation right shall include the right to bring suit in the Member's name. Member shall fully cooperate with PBHI when PBHI exercises this Benefit Program 's right of subrogation and Member shall not take any action or refuse to take any action which should prejudice the rights of this Benefit Program .

Non-duplication of Benefits/ Coordination of Benefits

Workers' Compensation Insurance – PBHI will not cover services provided to you, which duplicate the benefits to which you are entitled under any applicable Workers' Compensation law. You are responsible for taking whatever action is necessary to obtain payment under Workers' Compensation laws where payment under that system can be reasonably expected. PBHI will not provide or arrange for benefits for a work-related illness when the Member fails to file a claim within the filing period allowed by law or fails to comply with other applicable provisions of law under the Workers' Compensation Act.

In the event this Behavioral Health Benefit Program provides benefits which duplicate the benefits to which you are entitled under Workers' Compensation law, you are required to reimburse PBHI, or its nominee, for the cost of all such services and benefits administered by PBHI, at prevailing rates, immediately upon obtaining a monetary recovery whether by settlement or judgment.

In the event of a dispute arising between you and your Workers' Compensation coverage regarding your ability to collect under Workers' Compensation laws, PBHI may administer those behavioral health benefits described in this *Benefit Program Summary* until the dispute is resolved if the Member signs an agreement to reimburse PBHI for 100% of the benefits provided.

You and your Family Members are required to cooperate in protecting the interest of this Behavioral Health Benefit Program under this reimbursement provision by executing and delivering to PBHI or its nominee any and all liens, assignments or other documents.

Medicare Benefits – Member shall furnish information to PBHI concerning Member's eligibility for Medicare (Part A and/or Part B coverage) upon request by the Benefit Program . In those instances set forth below, this Benefit Program shall not furnish benefits, which duplicate the benefits to which Member is entitled as a Medicare beneficiary. Should the cost of Behavioral Health Services exceed the coverage of any applicable Medicare coverage, Benefit Program benefits shall be provided over and above such coverage.

If payment is made by this Benefit Program in duplication of the benefits available to Member as a Medicare beneficiary as set forth below, this Benefit Program may seek reimbursement from the insurance carrier, provider, or Member up to the amount this Benefit Program has paid for benefits which duplicate the Medicare coverage.

Benefit Program is Primary – In the following instances, this Benefit Program shall furnish benefits to Members with Medicare coverage, and Medicare shall be responsible for payment only to the extent the services provided to Member are not covered under this Benefit Program :

Aged Employees – Subscribers actively employed age sixty-five (65) or older or any dependent age sixty-five (65) or older, unless the Subscriber or dependent elects to retain Medicare as his or her primary insurer;

- Disabled Employees. Members eligible for Medicare as the result of a disability;
- End-Stage Renal Disease Beneficiaries (Initial Period). Members entitled to Medicare solely on the basis of end-stage renal disease, beginning the earlier of:
  - the month in which the Member initiates a regular course of renal dialysis, or
  - the month in which an individual who receives a kidney transplant could become entitled to Medicare.

Medicare is Primary – In the following instances this Benefit Program 's coverage shall be limited to the costs of Behavioral Health Services which are not covered by Medicare:

- Medicare Retirees. Members who meet the definition of Medicare Retiree set forth in Medicare laws and regulations;
- Members Who Elect Medicare as Primary. Members for which this Benefit Program would otherwise by primary, but who elect to have Medicare as their primary insurer.

Automobile, Accident, or Liability Coverage – This Benefit Program shall not furnish benefits that duplicate the benefits to which a Member is entitled under any other automobile, accident, or liability coverage. Member is responsible for taking whatever action is necessary to obtain the benefits of such coverage when it is available and shall notify PBHI of such coverage when available. If benefits are furnished by this Benefit Program in duplication of the benefits available to Member under other automobile, accident or liability coverage, this Benefit Program may seek reimbursement to the extent of the reasonable value of the benefits furnished by this Benefit Program from the insurance carrier, provider and Member.

Should the cost of Behavioral Health Services exceed the coverage of any applicable other coverage pursuant to this Section, this Benefit Program shall furnish benefits over and above such coverage.

Coordination of Benefits (COB) – This Benefit Program contains a COB provision that prevents duplication of payments. When a Member is eligible for benefits under any other valid coverage, the combined benefit payments from all coverage cannot exceed 100 percent of the Benefit Program 's covered expenses. All of the benefits furnished under this Benefit Program are subject to this provision. When this Benefit Program is secondary, all provisions (such as using a Participating Provider, and/or obtaining prior approval) must be followed. Failure to do so may result in no benefits or reduced benefits from PBHI.

The following rules determine which coverage pays first:

No COB Provision

a) If the other valid coverage does not include a COB provision, that coverage pays first and this Benefit Program pays secondary benefits.

Subscriber/Dependent

b) The benefits of a plan that covers the Member as a Subscriber shall be determined before the benefits of a plan, which covers such Member as a Dependent.

Dependent Child

c) Except as stated in subparagraph d) below, the benefits of the plan of the parent whose month and day of birth occurs earlier in a Calendar Year, shall be determined before the benefits of a plan of the parent whose month and day of birth occurs later in a calendar year. If the other coverage does not follow this birthday rules, then the father's coverage pays first.

Custodial/Non-custodial Parent

d) In the case of a Member for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

e) In the case of a Member for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. In addition, the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Court Decree Obligations

f) In the case of a Member for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding rules d) and 3), the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

Active/Inactive Employee

g) The benefits of a plan covering the person as a laid-off or retired employee, or as a dependent of such person, shall be determined after the benefits of any other plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person; and if either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then the next

Longer/Shorter Length of Coverage

h) When rules a) through g) do not establish an order of benefit determination, the benefits of a plan which has covered the Member for the longer period of time shall be determined before the benefits of a plan which has covered such Member the shorter period of time.

When this provision operates to reduce the total amount of benefits otherwise payable to a person covered under this Benefit Program during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Benefit Program .

Right to Receive and Release Necessary Information – For the purpose of determining the applicability of and implementing of the terms of this provision of this Benefit Program or any provision of similar purpose of any other Benefit Program , this Benefit Program may release to or obtain from any insurance company or other organization or person any information, with respect to any person, which this Benefit Program deems to be necessary for such purposes. Any person claiming

benefits under this Benefit Program shall furnish such information as may be necessary to implement this provision.

Facility of Payment – Whenever payment which should have been made under this Benefit Program in accordance with this provision have been made under any other plans, this Benefit Program shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Benefit Program and, to the extent such payments, this Benefit Program shall be fully discharged for liability under this Benefit Program.

Right of Recovery – Whenever payments have been made by this Benefit Program with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, this Benefit Program shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as this Benefit Program shall determine: any persons to or for or with respect to whom such payment were made, any insurers, service plan or any other organizations.

Covered Services

Behavioral Health Services are covered only when they are:

- Incurred while the Member is eligible for coverage under this Behavioral Health Benefit Program ;
- Pre-authorized by PBHI as Medically Necessary; and
- Rendered by a PBHI Participating Provider, except in the case of an Emergency.

PBHI will pay for the following Behavioral Health Services furnished in connection with the treatment of Mental Disorders and/or Chemical Dependency as outlined in the *Schedule of Behavioral Health Benefits*, provided the above criteria have been satisfied. You should refer to your *Schedule of Behavioral Health Benefits* for further information about your particular Behavioral Health Benefit Program .

I. **Mental Health Services** (including services for the diagnosis and treatment of SMI and SED conditions:
   A. Inpatient
      1. Inpatient Mental Health Services provided at an Inpatient Treatment Center or Day Treatment Center are covered when Medically Necessary, pre-authorized by PBHI, and provided at a Participating Facility.
      2. Inpatient Physician Care – Medically Necessary Mental Health Services provided by a Participating Practitioner while the Member is hospitalized as an inpatient at an Inpatient Treatment Center or is receiving services at a Participating Day Treatment Center and which have been pre-authorized by PBHI.
   B. Outpatient
      1. Outpatient Physician Care – Medically Necessary Mental Health Services provided by a Participating Practitioner and pre-authorized by PBHI. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.

II. **Chemical Dependency Services**

A. Inpatient
   1. Inpatient Chemical Dependency Services, including Medical Detoxification provided at an Inpatient Treatment Center – Medically Necessary Chemical Dependency Services, which have been pre-authorized by PBHI and are provided by a Participating Practitioner while the Member is confined in at a Participating Inpatient Treatment Center, or at a Participating Residential Treatment Center.
   2. Inpatient Physician Care – Medically Necessary Chemical Dependency Services, provided by a Participating Practitioner while the Member is confined at an Inpatient Treatment Center or at a Residential Treatment Center, or is receiving services at a Participating Day Treatment Center and which have been pre-authorized by PBHI.
   3. Chemical Dependency Services Rendered at a Residential Treatment Center – Medically Necessary Chemical Dependency Services provided by a Participating Practitioner, provided to a Member during a confinement at a Residential Treatment Center are covered, if provided or prescribed by a Participating Practitioner and pre-authorized by PBHI.

B. Outpatient
   1 Outpatient Physician Care – Medically Necessary Chemical Dependency Services provided by a Participating Practitioner and pre-authorized by PBHI. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.

III. **Other Behavioral Health Services**

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

Cost Control Reduction

The Percentage Payable is reduced by 30 percent when a Member leaves any Chemical Dependency Treatment Program prior to the authorization by the Case Manager of the discharge or transfer plan.

Exclusions

Unless described as a Covered Service in an attached supplement, all services and benefits described below are excluded from coverage under this Behavioral Health Benefit Program . Any supplement must be an attachment to this *Benefit Program Summary*.

1. Any confinement, treatment, service or supply not authorized by PBHI, except in the event of an Emergency or an Urgently Needed Service.
2. All services not specifically included in the PBHI *Schedule of Behavioral Health Benefits*, included with this *Benefit Program Summary*.
3. Services received prior to the Member's effective date of coverage, after the time coverage ends, or at any time the Member is ineligible for coverage.
4. Services or treatments which are not Medically Necessary, as determined by PBHI.
5. Services or treatment provided to you which duplicate the benefits to which you are entitled under any applicable Workers' Compensation law are not covered, as described in the Section of this *Benefit Program Summary* titled 'Workers' Compensation Insurance'.
6. Any services that are provided by a local, state or federal governmental agency are not covered except when coverage under this Behavioral Health Benefit Program is expressly required by federal or state law.
7. Speech therapy, physical therapy and occupational therapy services provided in connection with the treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay, including delayed language development, are not covered.
8. Treatments which do not meet national standards for mental health professional practice.
9. Routine, custodial, and convalescent care, long term therapy and/or rehabilitation. (Individuals should be referred to appropriate community resources such as school district or regional center for such services).
10. Services provided by non-licensed providers are not covered.
11. Pastoral or spiritual counseling.
12. Dance, poetry, music or art therapy except as part of a Behavioral Health Treatment Program.
13. School counseling and support services, home based behavioral management, household management training, peer support services, recreation, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, wraparound services, emergency aid to household items and expenses, and services to improve economic stability and interpretation services.
14. Genetic counseling services.
15. Community Care Facilities that provide 24-hour non-medical residential care.
16. Weight control programs and treatment for addictions to or dependency on tobacco, nicotine; treatment for caffeine dependency or dependency on any food substance.
17. Counseling for adoption, custody, family planning or pregnancy in the absence of a DSM-IV diagnosis.
18. Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence.
19. Personal or comfort items, and non-Medically Necessary private room and/or private duty nursing during inpatient hospitalization are not covered.

20. With the exception of injectible psychotropic medication, all non-prescription and prescription drugs, which are prescribed during the course of outpatient treatment, are not covered. Outpatient prescription drugs may be covered under your medical plan. Please refer to the Member disclosure materials describing the medical benefit. (Non-prescription and prescription drugs prescribed by a PBHI Participating Practitioner while the Member is confined at an Inpatient Treatment Center and non-prescription and prescription drugs prescribed during the course of inpatient Emergency treatment whether provided by a Participating or Non-Participating Practitioner, are covered under the inpatient benefit.)
21. Surgery or acupuncture.
22. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not Medically Necessary.
23. Neurological services and tests, including, but not limited to, EEGs, Pet scans, beam scans, MRI's, skull x-rays and lumbar punctures.
24. Treatment sessions by telephone or computer Internet services.
25. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations, or career counseling.
26. Educational services to treat developmental disorders, including autism, developmental delays or learning disabilities are not covered. A learning disability is a condition where there is a meaningful difference between a child's current academic level of function and the level that would be expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading and psychological and visual integration training as defined by the American Academy of Pediatrics Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review.
27. Treatment of problems that are not Mental Disorders are not covered, except for diagnostic evaluation.
28. Experimental and/or Investigational Therapies, Items and Treatments are not covered, unless required by an external, independent review panel as described in the Section of this *Benefit Program Summary* captioned "Experimental and Investigational Therapies." Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by the PBHI Medical Director or a designee. For the purpose of this *Benefit Program Summary*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/ guidelines are met:
    - It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA), and such approval has not been granted at the time of its use or proposed use.
    - It is a subject of a current investigation of new drug or new device (IND) applications on file with the FDA.
    - It is the subject of an ongoing clinical trial (Phase I, II, or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and the Department of Health and Human Services.
    - It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
    - It is being delivered or should be delivered subject to approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).

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

A Member with a Life-Threatening or Seriously Debilitating condition may be entitled to an expedited external, independent review of PBHI's coverage determination regarding Experimental or Investigational therapies as described in the Section of this *Benefit Program Summary* captioned "Expedited Review Process".

29. Expenses incurred due to liable third parties are not covered, as described in the Section of this *Benefit Program Summary* titled "Third Party Liability".
30. Mental Health Services rendered at a Residential Treatment Center or other facilities or institutions that are not Inpatient Treatment Centers.
31. Treatment for conditions often described as compulsive gambling.
32. Services which are provided by a non-licensed Practitioner or a non-licensed Facility.
33. Methadone maintenance or treatment.
34. Durable medical goods.
35. Nutritional counseling.
36. Catastrophic illness diagnosis.
37. Physical needs from suicide.
38. Medical Detoxification.
39. Services furnished by a relative.
40. Counseling in preparation for or associated with a sex change operation.

Miscellaneous Provisions

Plan Administration

For a complete description of the Plan Administration and authorized agents, please refer to your LANS SPD.

Administration of the Plan

The LANS Benefits and Investment Committee is the Plan Administrator. If you have a question, you may direct it to:

Benefits and Investment Committee
TA-3 Building 261
2nd Floor
Los Alamos, NM 87545

Mailing Address:

Benefits and Investment Committee
P.O. 1663, Mail Stop P280
Los Alamos, NM 87544

Claims under the Benefit Program are processed by PacifiCare Behavioral Health, Inc. at the following address and phone number:
PacifiCare Behavioral Health, Inc.
Claims Department
P.O. Box 31053
Laguna Hills, CA 92654
(800) 817-8811

Group Contract Number

The Group Contract Number for this Benefit Program is: 10000206

Amendments

This *Benefit Program Summary* may be amended or terminated at any time in the Plan Sponsor's discretion. No one has the authority to make any oral modification to this *Benefit Program Summary*.

Definitions

These definitions apply to the terms used in your *Benefit Program Summary*, as well as the *Schedule of Behavioral Health Benefits*. Please refer to the *Schedules of Behavioral Health Benefits* to determine which of the definitions below apply to your Benefit Program .

Administrative Service Agreement. The *Agreement* for the provision of Behavioral Health Services between the Plan Sponsor and PBHI.

Assessment Process. The process by which the PBHI Clinician gathers information to determine Medical Necessity. The Member is asked a series of questions about the current life circumstances that are contribution to his/her lack of psychological well-being. The interview includes specific questions about areas of emotional duress and to what degree there is an impairment of functioning at the Member's work, leisure and daily activities. The information is quantified into a numerical basis to facilitate tracking the quality of treatment and the effectiveness of treatment.

Behavioral Health Services. Services for the Medically Necessary diagnosis and treatment of Mental Disorders and Chemical Dependency, which are provided to Members pursuant to the terms and conditions of the PBHI Behavioral Health Benefit Program .

Behavioral Health Plan. The PBHI Behavioral Health Benefit Program that includes coverage for the Medically Necessary diagnosis and treatment of Mental Disorders and Chemical Dependency, as described in the Administrative Services, this *Benefit Program Summary*, and the *Schedule of Behavioral Health Benefits*.

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

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

Benefit Program. Definity Health Plan.

Calendar Year. The period of time from 12:00 A.M. on January 1 through 11:59 P.M. on December 31. Each succeeding like period will be considered a new Calendar Year.

Calendar Year Deductible. The amount of Covered Expense a Member is responsible to pay per Calendar Year before benefits become payable under this Employee Behavioral Health Benefits Benefit Program .

Chemical Dependency. An addictive relationship between a Member and any drug, alcohol or chemical substance that can be documented according to the criteria in the DSM-IV-TR. Chemical Dependency does not include addiction to or dependency on (1) tobacco in any form or (2) food substances in any form.

Chemical Dependency Inpatient Treatment Program. A structured medical and behavioral inpatient program aimed at the treatment and alleviation of Chemical Dependency.

Chemical Dependency Services. Medically Necessary services provided for the treatment of Chemical Dependency, which have been pre-authorized by PBHI.

Chemical Detoxification. Routine treatment and stabilization for symptoms resulting from withdrawal from chemical substance, including drugs or alcohol, which does not require intensive nursing, monitoring or procedures such as intravenous fluids. Where such services are a covered benefit, Members must:

- Obtain medical clearance from Primary Care Physician prior to receiving Chemical Detoxification from PBHI, and
- Receive Chemical Detoxification services from a Participating Provider.

Contracted Rate. The rate, or percentage thereof, that the Participating Provider agrees to accept from Plan Sponsor as payment in full for covered services, excluding any applicable Copayments by the Member.

Copayments. Costs payable by the Member at the time Covered Services are received. Copayments may be a specific dollar amount or a percentage of Covered Charges as specified in this *Benefit Program Summary* and are shown on the PBHI *Schedule of Behavioral Health Benefits*.

Covered Services. Medically Necessary Behavioral Health Services provided pursuant to the *Administrative Services Agreement*, this *Benefit Program Summary* and *Schedule of Behavioral Health Benefits* for Emergencies or those Behavioral Health Services which have been pre-authorized by PBHI.

Covered Expenses. An expense that:

- is incurred for a Behavioral Health Service provided to a Member while that person is covered under this Benefit Program ;
- does not exceed the Maximum Benefit that may apply to the expense; and
- does not exceed the applicable negotiated fees of a Participating Provider.

Customer Service Department. The department designated by PBHI to whom oral or written Member issues may be addressed. The Customer Service Department may be contacted by telephone at 1-800-817-8811 or in writing at:

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

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

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

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

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

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

If you or your Dependent are temporarily outside of New Mexico, experience a situation which requires Behavioral Health Services, and a delay in treatment from a PBHI Participating Provider in New Mexico would result in a serious deterioration to your health, the situation will be considered an Emergency.

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

Experimental and Investigational Treatment. An unproven procedure or treatment regimen that does not meet the generally accepted standards of usual professional medical practice in the general medical community.

Facility. A entity which is duly licensed by the state in which it operates to provide inpatient, day treatment, partial hospitalization or outpatient care for the diagnosis and/or treatment of Chemical dependency of Mental Disorders.

Grievance Procedure. The procedure for reviewing complaints of Members.

Group Therapy. Goal-oriented Behavioral Health Services provided in a group setting (usually about 6 to 12 participants) by a PBHI Participating Practitioner. Group Therapy can be made available to the Member in lieu of individual outpatient therapy when appropriate. Please refer to you *Schedule of Behavioral Health Benefits* for further information.

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

- provides 24-hour nursing and medical supervision;
- has established a written referral relationship with a local hospital for patients beyond its scope of treatment capability; and
- is licensed, certified, or approved as such by the appropriate state agency.

LANS. Los Alamos National Security, LLC.

LANS SPD. LANS Welfare Benefit Plan for Employees Summary Plan Description.

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

Medical Detoxification. In most cases of alcohol, drug or other substance abuse or toxicity, outpatient treatment is appropriate unless another medical condition requires treatment at an Inpatient Treatment Center.

Medical Expenses. Any costs related to physical illness or injury.

Medically Necessary (or Medical Necessity). Refers to Behavioral Health Services or supplies for treatment of a Mental Disorder or Chemical Dependency that are determined by PBHI's Medical Director (or designee) to be:

- Rendered for the treatment and diagnosis of a Mental Disorder and Chemical Dependency, as defined by the DSM-IV-TR and limited to the impairment of a Member's mental, emotional or behavioral functioning,
- Appropriate for the severity of symptoms, consistent with diagnosis, and otherwise in accordance with generally accepted medical practice and professionally recognized standards, which shall include the consideration of scientific evidence;
- Not furnished primarily for the convenience of the Member, the attending physician, or other provider of service; and
- Furnished at the most cost-effective manner, which may be provided safely and effectively to the Member.
  "Scientific evidence", as referenced above, shall include peer reviewed medical literature, publications, reports and other authoritative medical sources.

Medicare. The Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act as amended.

Medicare Retiree. A Member who is:

- eligible for Medicare Part A and Part B;
- no longer eligible for benefits as an active employee or a Dependent of an active employee;
- properly enrolled in this Behavioral Health Benefit Program ; and
- eligible for benefits under this Behavioral Health Benefit Program pursuant to the requirements set forth in your LANS SPD.

Member. The Subscriber or any Dependent, as described in your LANS SPD.

Mental Disorder. A mental or nervous condition diagnosed by a licensed Participating Practitioner according to the criteria in the DSM-IV-TR resulting in the impairment of a Member's mental,

emotional, or behavioral functioning. Mental Disorders include the Severe Mental Illness of a person of any age and the Serious Emotional Disturbances of a child.

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

Open Enrollment Periods. The periods during which all eligible employees and their eligible Dependents may enroll in this Behavioral Health Benefit Program .

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

PacifiCare Behavioral Health, Inc. ("PBHI"). The Administrator that the Plan Sponsor has contracted with for administrative services, including but not limited to premium billing and collection, claims payment, case management, pre-authorization and provider access.

Participating Facility. A health care or residential facility which is duly licensed by the state in which it operates to provide inpatient, residential, day treatment, partial hospitalization, or outpatient care for the diagnosis and/or treatment of Covered Behavioral Health Services and which has entered into a written agreement with PBHI.

Participating Practitioner. A psychiatrist, psychologist, or other allied behavioral health care professional who is qualified and duly licensed or certified to practice his or her profession in the state in which he or she operates and who has entered into a written agreement with PBHI to provide Covered Behavioral Health Services to Members.

Participating Providers. Participating Practitioners, Participating Preferred Group Practices and Participating Facilities, collectively, each of which has entered into a written agreement with PBHI to provide Behavioral Health Services to Members.

Participating Preferred Group Practice. A provider group or independent practice association duly organized and licensed in the state in which it operates to provide Behavioral Health Services through agreements with individual behavioral health care providers, each of whom is qualified and appropriately licensed to practice his or her profession in New Mexico.

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

Plan. LANS Welfare Benefit Plan for Employees.

Plan Sponsor. LANS

Practitioner. A psychiatrist, psychologist or other allied behavioral health care professional who is qualified and duly licensed or certified to practice his or her profession the state in which he or she operates.

Pre-Authorized Services. Those Behavioral Health benefits described in the *Schedule of Behavioral Health Benefits*, and which are Medically Necessary and authorized by a PBHI Clinician.
Prevailing Rate. The usual, reasonable and customary rates for a particular Behavioral Health Services in the service area.

Quality Review. The PBHI procedure of reviewing complaints related to the quality or appropriateness of Behavioral Health Services provided or arranged by PBHI or a Participating Practitioner.

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

Schedule of Behavioral Health Benefits. The schedule of Behavioral Health Services which is provided to Members under this Behavioral Health Benefit Program . The *Schedule of Behavioral Health Benefits* is attached and incorporated in full and made a part of this document.
Subscriber. The person who enrolls in the PBHI Behavioral Health Benefit Program and who meets all the applicable eligibility requirements of the Group and PBHI, and for whom Benefit Program Premiums have been received by PBHI.

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

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

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

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

3120 Lake Center Drive

Santa Ana, CA 92704-6917

Customer Service
800-817-8811
888-877-5378 (TDHI)

Visit our Web site @ www.pbhi.com

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PBHB1658 4/06