

About This Booklet

To understand your MHN benefits (the “Plan”), please read this Combined Evidence of Coverage and Disclosure form booklet (“Evidence of Coverage”) carefully. This Evidence of Coverage discloses the terms and conditions of coverage and can help you understand your rights and responsibilities as a Member (as defined in the Policy/Certificate described below). This Evidence of Coverage is only a summary of the health plan contract (the “Agreement”) between MHN Services (“MHN”) and the entity named in the Policy/Certificate as the Policyholder (defined herein as “Employer” or “Group”).

MHN Services administers the behavioral healthcare services portion of this Plan in accordance with the Health Net Life Insurance Company Group Policy/Certificate (the “Policy/Certificate”) underwritten and issued to the Policyholder by Health Net Life Insurance Company. Administration of the Policy/Certificate is regulated by the California Department of Insurance. Any provisions required to be in the Policy/Certificate by law shall bind MHN whether or not provided in the Policy/Certificate. Capitalized terms used herein and not defined herein shall have the meaning set forth in the Policy/Certificate attached hereto as Appendix A.

This Evidence of Coverage, the Agreement and the Policy/Certificate are subject to change, without the Members’ consent, according to the provisions of the Agreement. If this Evidence of Coverage has been issued to an existing MHN Employer or Group, it replaces the former Evidence of Coverage, effective upon the date of the Agreement. Please refer to the most recent Evidence of Coverage, as benefits may have changed from those stated in the prior Evidence of Coverage.

By enrolling or accepting services under this Plan, Members agree to abide by all the terms, conditions and provisions stated in the Agreement, the Policy/Certificate and in this Evidence of Coverage. Members must notify MHN of any change in residence and any circumstances that may affect entitlement to coverage or eligibility under this Plan. Members must also immediately disclose to MHN if they have filed a Workers’ Compensation claim, or were injured by a third party. MHN reserves the right to make payment of benefits, at its sole discretion, directly to the Provider or to the Member.

As a condition of enrollment and to receive benefits under this Plan, MHN, its agents, independent contractors and Participating Providers (as defined in the Policy/Certificate) shall be entitled to release to, or obtain from, any person, organization or government agency, any information and records, including patient records of Members, which MHN requires to administer the benefits or is obligated to provide pursuant to legal process, or federal, state or local law. Each Member expressly consents to, authorizes and directs providers to furnish to MHN such medical, mental health records and other information, as MHN may request for the purposes of administering this Plan.

Please note: This Evidence of Coverage is not intended to include all of the information that an ERISA plan sponsor, who is usually the Employer, needs to disclose to plan participants regarding health plan benefits or other types of benefits in a summary plan description (“SPD”). Please review your health plan’s SPD for required information that is specific to your plan sponsor and/or health plan. The ERISA plan sponsor, not MHN, is solely responsible for providing the SPD to ERISA plan participants.

Program Overview

Who Is Eligible For Benefits?

The following individuals are eligible for benefits as Members (as defined in the Policy/Certificate):

As any member of the LA County Firefighters, Local 1014, who is actively employed on a full-time basis with a political subdivision of government such as fire protection, fire prevention, or security personnel and any members of a qualified local affiliated with LA County Firefighters, Local 1014, you are eligible to participate in the Employee Assistance Program.

Also, officers and employees of duly appointed representatives of the LA County Firefighters, Local 1014, and retired members who have at least five (5) years continuous and uninterrupted coverage under the plan immediately prior to retirement and who continue uninterrupted coverage under the plan and throughout their retirement are eligible to participate in the Employee Assistance Program.

Additionally, your spouse and dependent children age nineteen (19) or less, or age twenty-six (26) or less if a full-time student, or of any age and incapable of self-sustaining employment due to a mental or physical handicap are eligible.

When Does Coverage Begin And End?

Your eligibility begins on the first of the month following your date of hire. Your eligibility ends upon termination of employment, or when your employer's contract with MHN is terminated. Your eligible family members are covered during the same time you are.

The Agreement between MHN and your Employer or Group specifies how long the Plan remains in effect and under what conditions your Employer or Group may terminate the Agreement. Upon termination of the Agreement by either party, your Employer or Group is responsible for notifying you about the change in coverage.

Upon termination of employment, you and/or your eligible Dependents may continue coverage under COBRA. See also the attached Policy/Certificate for information regarding continuation of coverage later on in this booklet.

Termination of Member's Benefits

MHN may immediately terminate the coverage of a Member upon notice that the Member:

- Provided false or misleading information; or omitted or failed to provide true and accurate information to the Employer or Group or MHN.
- Obtained or attempted to obtain services or benefits by means of false, misleading, or fraudulent information, acts, or omissions.
- Assisted a person who is not a Member to obtain services.

- Assaulted, harassed or threatened the life or well-being of MHN’s staff, the provider or their affiliated personnel, or any other Member.
- Conducted themselves in a manner that is deemed to be threatening, harassing or violent to any provider or MHN representative.
- Disrupted the operations of a provider or MHN to the extent that the normal operations of either the provider’s office or MHN are adversely impacted.

MHN may also terminate the coverage of a Member upon **thirty (30) days** prior written notice for the following:

- Repeated and unreasonable demands for services that are not Medically Necessary Services.
- Failure to pay any copayment.
- Violation of any provision of the Agreement.

For California Members: Your coverage cannot be cancelled, nor can you be denied renewed coverage, because of your health status or requirements for service. If you think this has happened, you may request a review by the California Department of Insurance.

How Can I Contact MHN?

You can call MHN 24 hours a day, 7 days a week, 365 days a year. Your dedicated access number is at 1-800-777-9355. MHN staff is available to assist you in obtaining the appropriate referral, answer questions about your benefits or connect you immediately to a staff clinician for a clinical emergency.

Employee Assistance Program & Behavioral Healthcare Services: Two Components Working Together

Employee Assistance Program (“EAP”)

The EAP provides short-term counseling and consultation services with counselors under contract with MHN (“Participating Practitioners”), who identify, discuss, and develop a plan of action to help resolve your problem. For longer-term care, your Participating Practitioner works with MHN to facilitate continued treatment based on your coverage.

You can access the EAP by calling MHN 24 hours a day, 7 days a week, 365 days a year at 1-800-777-9355. Referral and authorization are always required for EAP services. MHN only provides EAP referrals to its Participating Practitioners.

The EAP provides 50-minute sessions with a MHN Participating Practitioner for a wide range of personal issues. You are eligible to receive a specified number of counseling sessions, as described in the Appendix section of this booklet. Your Employer or Group has paid the cost of the EAP service. There are no copayments, coinsurance, or deductible payments. Please note, if

you are eligible for life management services as set forth in the Appendix section of this booklet, these services are telephonic.

The EAP benefit does **not** provide coverage for (1) inpatient treatment of any kind or outpatient treatment for any medically treated illness; (2) prescription drugs; (3) treatment/services for mental retardation or autism; (4) counseling services beyond the number of sessions covered; (5) services by non-Participating Practitioners; (6) counseling required by law, a court, or paid for by Workers' Compensation; (7) formal psychological evaluations and fitness-for-duty opinions; (8) investment advice (nor does MHN loan money or pay bills); (9) legal representation in court, preparation of legal documents, or advice related to taxes, patents or immigration; or (10) tax representation or preparation services.

If you use MHN's services, your treatment will be afforded the confidentiality protected by state and federal law. Exceptions to confidentiality include, but are not limited to, mandatory reporting of child and elder abuse, subpoena or court order and certain disclosures made by persons dangerous to themselves or others. A statement describing MHN's policies and procedures for preserving the confidentiality of medical records is located at the back of this booklet and will be furnished upon request. You also may obtain a copy of such statement and other information about MHN services by accessing MHN's web site at www.mhn.com.

You acknowledge that health care providers may disclose health information about you or your dependents, including information regarding substance abuse or mental/emotional conditions, to MHN. MHN uses and discloses this information for purposes of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement or disease or case management programs.

Behavioral Healthcare Services

MHN administers inpatient and outpatient Behavioral Healthcare Services covered under this Plan according to the Policy/Certificate underwritten and issued to your Group by Health Net Life Insurance Company, as described in Appendix A to this Evidence of Coverage. Under this Policy/Certificate, MHN authorizes and pays for Medically Necessary (as defined in the Policy/Certificate) treatment only. If MHN determines that the requested care is Medically Necessary and covered under this Plan, coverage will be authorized according to the benefits, terms and conditions set forth in the Policy/Certificate. A detailed explanation of your Group's Behavioral Healthcare Services is provided in the Appendix section of this booklet.

How Do I Obtain Behavioral Healthcare Services?

Emergency Care: If you are experiencing severe symptoms and are impaired in your functioning to the extent that you present an immediate danger to yourself or others, it is an Emergency. If you are in crisis and need immediate assistance, call the **911** emergency response system or go to the nearest emergency room. MHN's counselors also are available 24 hours a day, 365 days a year for immediate telephone intervention. In an Emergency, pre-authorization for treatment is **not** required. However, you, your provider, or your family member must call MHN within 24 hours of an Emergency admission for authorization of care rendered following stabilization of the Emergency.

MHN may limit coverage under this Plan to services and supplies rendered by Participating Providers if MHN determines that transfer to a Participating Provider is medically appropriate, or MHN may apply your out-of-network benefits, if any. Your consent and cooperation with this transfer is a condition of in-network coverage under this Plan. Refusal of transfer may result in denial of coverage from the date that MHN determines it is medically appropriate for the Member to transfer to a Participating Provider, or the application of out-of-network benefits, if available.

Non-Emergency Care: For in-network coverage, call MHN at 1-800-777-9355 for a referral to a Participating Provider and authorization of services according to the procedures set forth in the Policy/Certificate. MHN will review your treatment with your Participating Provider to determine whether such treatment is Medical Necessary and the appropriate level of care for your problem. Except in an Emergency, MHN must authorize all in-network services in advance, including transfers to different levels of care and any additional services. For out-of-network coverage, please consult the Policy/Certificate for authorization requirements. If you think you require an inpatient, residential or structured treatment program, except in an Emergency, you must obtain authorization from MHN in advance, whether in-network or out-of-network. Authorization of coverage by MHN is conditioned upon the Member's eligibility for coverage at the time the Covered Services are received. If the Member was not eligible for coverage after authorization was given, MHN will deny coverage accordingly.

Utilization Review

This Plan includes prior, concurrent and retrospective reviews of certain proposed treatments to determine whether the proposed treatment is a Medically Necessary Service and if the services are covered. An example of concurrent review is MHN's review of whether current use of an inpatient facility is the appropriate treatment setting for the patient's symptoms. An example of retrospective review is MHN's review of whether past use of a hospital was appropriate for the patient's symptoms. In the event that the required clinical information is not provided by the provider in support of the treatment, MHN will deny coverage of such treatment.

The final judgment of the reviewer or professional review organization is not a substitute for the independent judgment of the treating provider as to the course of treatment. Utilization review decisions that are not consistent with a treating provider's determination do not preclude treatment or hospitalization – but do determine MHN's coverage for such treatment or hospitalization under this Plan.

A **Medically Necessary Service** is defined as psychiatric and/or other related health care services proposed by a provider, which must meet all of the following conditions as determined by MHN:

- The requested services facilitate the diagnosis and/or active treatment of a covered current DSM–IV Axis I Mental Disorder or substance-related disorder.
- The proposed treatment plan represents an active, necessary and appropriate intervention for the timely resolution of your symptoms and the restoration to baseline level of functioning. The proposed services are not primarily custodial in nature.
- The type, level and length of the proposed services and setting are consistent with MHN's level of care criteria and guidelines and are rendered in the least restrictive level of care in which the patient can be safely and effectively treated.

- The proposed treatment is not experimental in nature; that is, its safety and efficacy have been clearly demonstrated and widely accepted in the modern psychiatric literature.
- The proposed treatment plan has been demonstrated in peer reviewed journals to be at least equally effective in bringing about a rapid resolution of symptoms when compared to possible alternative treatment interventions.
- The proposed treatment plan utilizes clinical services in an efficient manner when compared to alternative treatment interventions and contributes to effective management of your benefit.
- Treatment is provided by a mental health professional licensed to practice independently who meets MHN's credentialing standards.

Claiming Benefits (Applicable to ERISA Plans)

The following provisions are applicable for Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans. Please contact your Employer or Group to determine whether this benefit plan is subject to ERISA. All actions described in this section to be taken by a claimant (Member), likewise may be taken by a representative of the claimant duly authorized by him or her to act on his or her behalf in such matters (an "Authorized Representative"). MHN may require such evidence it deems reasonably necessary or advisable to verify the authority of any such representative to act. You do not need to complete claims forms for Behavioral Healthcare Services obtained by Participating Providers. Participating Providers will file the claim for you and will be paid directly by MHN. Non-Participating Provider claims must be submitted in accordance with the terms of the Policy/Certificate.

Types of Claims or Requests for Authorization

The requirements for processing claims or requests for authorization depend on the type of claim or request submitted. A claim or request is defined by ERISA in one of the following categories: urgent, pre-service, post-service or concurrent.

Urgent Care Claims: An Urgent Care Claim is any claim for medical care or treatment with respect to which the application of standard processes for making care decisions:

- Could seriously jeopardize your life, health or ability to regain maximum function; or
- Would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Determinations regarding the severity of pain must be made by a physician with knowledge of your medical condition.

If a physician with knowledge of your medical condition determines that your claim is an Urgent Care Claim, MHN will treat it as such. A health care professional with knowledge of your medical condition shall be permitted to act as your Authorized Representative for purposes of filing and appealing an Urgent Care Claim.

Pre-Service Claims: A Pre-Service Claim is a request for authorization of medical care or treatment that you have not yet received, which is conditioned in whole or in part on MHN's approval of coverage in advance of obtaining the medical care.

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

Concurrent Care Claims: A Concurrent Care Claim is a request for authorization of an extension or modification to an approved course of treatment that is already in progress, such as an inpatient hospitalization.

Failure To Follow Procedures In Submitting A Claim

If you fail to follow the proper procedures when filing a Pre-Service Claim or Urgent Care Claim, MHN will notify you regarding the proper procedures to be followed to complete the claim within:

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

Insufficient Information

If MHN requires additional information in order to make a determination, you will be notified regarding what information is necessary and given a reasonable amount of time to provide MHN with the requested information.

Notice Of Determination

Note: MHN reserves the right to extend the time periods specified below as allowed by law if such extension is necessary due to matters beyond the control of MHN.

Urgent Care Claims: MHN will notify you of its decision (whether or not to pay the claim) as soon as possible, taking into account medical exigencies, but not later than 72 hours after MHN's receipt of your Urgent Care Claim.

If you fail to provide MHN with information sufficient to enable MHN to decide your claim, you will be notified of such failure as soon as possible, but not later than 24 hours after MHN's receipt of the insufficient information. You will then be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. After you provide the specified information, MHN will provide you with its decision on the claim as soon as possible, but in no case later than 48 hours after the earlier of:

- MHN's receipt of the specified information, or
- The end of the period afforded you to provide the specified additional information.

Pre-Service Claims: MHN will notify you of its decision (whether or not to pay the claim) as soon as possible but no later than fifteen (15) days after MHN's receipt of your Pre-Service Claim.

MHN reserves the right to a single extension of this 15-day period of an additional 15 days if MHN determines that the extension is necessary due to matters beyond its control. You will be notified prior to the expiration of the initial 15-day period of the circumstances requiring the extension of the time and date by which MHN expects to render a decision.

If the extension described above is necessary because you failed to submit the information necessary to decide the claim, the notice of extension must describe specifically the required information. You shall be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

Post-Service Claims: MHN will notify you of its decision (whether or not to pay the claim) as soon as possible no later than 30 days after MHN's receipt of your Post-Service Claim. MHN reserves the right to a single extension of this 30-day period for up to an additional 15 days if MHN determines that the extension is necessary due to matters beyond its control. You will be notified prior to the expiration of the initial 30-day period of the circumstances requiring the extension of the time and date by which MHN expects to render a decision.

If the extension is necessary because you failed to submit the information necessary to decide the claim, the notice of extension will describe specifically the required information. You will be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

Concurrent Care Claims: If MHN has approved an ongoing course of treatment to be provided to you over a period of time or a number of treatments, MHN's reduction or termination of the course of treatment (other than by amendment or termination of this Plan) constitutes a denial of your claim. Any reduction or termination by MHN of the approved course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed is considered an adverse benefit determination. In the event of such a denial, MHN will notify you in sufficient time prior to the reduction or termination in order to allow claimant to appeal and obtain a determination on appeal before the benefit is reduced or terminated.

If the claimant requests that the course of treatment be extended beyond the period of time or number of treatments originally approved and such request is an Urgent Care Claim, the request will be decided as soon as possible, taking into account the medical exigencies. MHN will notify you of its benefit determination (whether or not to pay the claim) not later than 24 hours after its receipt of the claim, provided the request for an extension is made at least 24 hours prior to the expiration of the originally approved period of time or number of treatments.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment and the request to extend is an Urgent Care Claim, the claim will be decided according to the Urgent Care Claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to Pre-Service Claim or Post-Service Claim time frames, whichever applies.

If the Claim or Request Is Denied

If the claim or request is denied, delayed or modified due to determination that the services or treatment were not Medically Necessary or appropriate, either in whole or in part, you will receive a written notice explaining the reasons for the determination including:

- The specific reason or reasons why the claim was denied, delayed or modified.
- Reference to the MHN plan provisions on which the decision is based.
- If more information is needed, a description of any material necessary to process the claim properly and why the materials are needed.
- A description of MHN's appeal process and any time limits applicable to such procedures.
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial of your claim on appeal.
- A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in denying the claim, or a statement that a copy will be provided free of charge upon request.
- If your claim or request was denied based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the MHN plan to the claimant's medical circumstances or a statement that such an explanation will be provided free of charge upon request.
- If your claim or request was an Urgent Care Claim, a description of the expedited review process available to the claimant. This initial determination may be explained orally, followed by a written or electronic notice containing that information within 3 days.

Appealing A Denial Of Medical Benefits

After receiving a denial, to appeal it, you or your Authorized Representative must submit a written request for review by MHN. The request must be made within 180 days of the denial and should be accompanied by documents or records in support of the appeal. As part of the review procedure, you or your Authorized Representative are entitled to:

- Examine and obtain copies, free of charge, of all health plan documents, records and other information that were used in making the determination.
- Submit written comments, documents, records, and other information relating to the claim or request.
- Obtain information identifying the medical or vocational experts whose advice was obtained on behalf of MHN in connection with the denial of the claim or request. (You are entitled to this information even if MHN did not rely on the information in making its determination).
- Have someone act as your representative in the review procedure, if you wish.

In addition, MHN's review of the appeal must be conducted in accordance with the following rules:

- MHN may not defer to the initial denial of the claim or request. Review of the appeal must be conducted by an MHN Peer Reviewer who is neither the individual who initially denied the claim or request, nor a subordinate of such individual.

- If denial of the initial claim or request was based in whole or in part on a medical judgment (including decisions as to whether a drug, treatment, or other item is experimental, investigational, or not Medically Necessary or appropriate), an MHN Medical Director must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional cannot be an individual who was consulted in connection with the initial decision on the claim or request, nor the subordinate of such an individual.
- If you are appealing the denial of an Urgent Care Claim, the request for an expedited appeal may be submitted orally or in writing, and all necessary information may be transmitted between you and MHN by telephone, facsimile or any other available efficient method.

MHN will notify you of the decision on the appeal. Such notice will be provided to you:

- As soon as possible, taking into account the medical exigencies, but not later than 72 hours after MHN's receipt of the appeal of an Urgent Care Claim.
- Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after MHN's receipt of the appeal of a Pre-Service Claim.
- Within a reasonable period of time, but not later than 30 days after MHN's receipt of the appeal of a Post-Service Claim.

If the appeal is denied, a written notice containing the information set forth below will be provided.

- The specific reason or reasons for the denial of the appeal.
- Reference to the specific MHN plan provisions on which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial of the claim on appeal, that you and MHN may have other voluntary alternative dispute resolution options such as arbitration or mediation, and that the claimant should contact the U.S. Department of Labor to find out what alternatives may be available.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, a copy of that rule, guideline, protocol or criterion, or a statement that a copy will be provided free of charge upon request.
- If the claim or request was denied based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the MHN plan to the claimant's medical circumstances or a statement that such an explanation will be provided free of charge upon request.

MHN Levels of Appeal

A request for an appeal because of a denial of authorization can be made by Members, providers or the Member's Authorized Representative. Questions about the appeal processes explained below may be directed at any time to the MHN Appeals Unit at (888) 426-0028.

MHN Mandatory Internal Review: If the Member has an Urgent Care Claim, the Member or his or her provider or Authorized Representative can request an expedited appeal of a denial of authorization for payment by calling MHN at 1-800-777-9355. An appeal will be arranged and concluded within seventy-two hours with a peer reviewer different from the one who issued the initial denial. MHN expedites both concurrent and pre-service appeal requests.

Standard Written Appeal: If the Member does not have an Urgent Care Claim, the Member, provider or Authorized Representative may submit a Standard Written Appeal within 180 days from the date of the previous adverse determination. Appeal determinations are made within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt of the appeal request. A peer reviewer different from the one who made the initial denial decision reviews the request. The appeal request, along with any records or other information to be considered, should be sent to:

MHN
Attn: *Appeals Unit*
503 Canal Boulevard
Pt. Richmond, CA 94804

Independent Medical Review (Voluntary for Members): If the decision constitutes a denial of benefits and the Member has exhausted the MHN Mandatory Internal Review described above, the Member may request a voluntary appeal by an independent review organization in accordance with the procedures outlined in the denial letter.

Arbitration

Sometimes disputes or disagreements may arise between you (including your enrolled family members, heirs or personal representatives) and MHN regarding the construction, interpretation, performance or breach of this Evidence of Coverage, or regarding other matters relating to or arising out of your membership in this Plan. Typically such disputes are handled and resolved through the MHN Grievance and Appeal Process described above. However, in the event that a dispute is not resolved in that process, MHN uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with MHN involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to becoming a MHN Member, you agree to submit all disputes you may have with MHN, except those described below, to final and binding arbitration. Likewise, MHN agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and MHN are bound to use binding arbitration as the final means of resolving disputes that

may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by MHN's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

MHN's binding arbitration process is conducted by selection of mutually acceptable arbitrator(s). The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that total amount of damages claimed is \$200,000 or less, the parties shall, within 60 days of the demand for arbitration to MHN, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than \$200,000. In the event that total amount of damages is over \$200,000, the parties shall, within 60 days of the demand for arbitration to MHN, appoint a panel of three neutral arbitrators (unless less than three is mutually agreed upon), who shall hear and decide the case.

Arbitration can be initiated by submitting a demand for arbitration to MHN at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Litigation Administrator
21650 Oxnard Street, #1520
Woodland Hills, Ca. 91367

Upon receipt of a demand for arbitration by MHN, the parties will have 60 days to attempt to reach an agreement to select mutually acceptable arbitrator(s) as outlined above. If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) who would hear and decide the matter.

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this Evidence of Coverage, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law, and that award will be binding on all parties. The parties will share equally the arbitrator's fee involved in the arbitration. Each party also will be responsible for their own attorneys' fees.

Effective for plan years beginning on and after July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are *not* required to submit disputes about certain "adverse benefit determinations" made by MHN to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by MHN to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and MHN may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Civil Actions Under ERISA

In the event the Member's Plan is subject to ERISA (contact your Employer for this determination), effective for plan years beginning on or after July 1, 2002, the Member has the right to file a civil action under Section 502(a) of ERISA if a claim for benefits has not been approved after all mandatory reviews as outlined above have been completed. This means that the Member is not required to, but may voluntarily participate in, the voluntary Independent Medical Review and Arbitration processes described above. The Member may also have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office or applicable State insurance regulatory agency.

About Our Providers

Choice of Participating Providers

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

MHN offers members a network of Participating Providers that include:

- Psychiatrists
- Psychologists
- Clinical social workers
- Marriage and Family Therapists
- Masters level counselors
- Chemical dependency, rehabilitation and mental health facilities

Provider Information

MHN maintains a database of information on Participating Providers, including their address, telephone number, professional degree, board certification and subspecialty qualifications. If you have questions regarding any of our Participating Providers, or you would like a list of Participating Providers located within your geographic area, you can call us at 1-800-777-9355. You may also view and print a list of MHN's Participating Providers via our website at www.mhn.com. MHN's roster of Participating Providers is subject to change. Although MHN updates its website on a weekly basis so that the information includes only providers currently available to service members, we cannot guarantee the initial or continued availability of any particular Participating Provider.

Remember that all Covered Services must be provided by a Participating Provider unless coverage for non-Participating Providers is available as set forth in the Policy/Certificate. For authorization and a referral to a Participating Provider, please call MHN at 1-800-777-9355. Exceptions to this rule are cases of an Emergency, if authorization is provided in writing by MHN's Medical Director or his/her designee, or as otherwise permitted under this Plan.

Can I Change Providers?

When you call MHN, every attempt is made to help you select a Participating Provider who will best meet your needs. If you are dissatisfied with the Participating Provider, you may call us for a referral to another Participating Provider. There may also be times when you require care that your initial Participating Provider is unable to administer. In this case, just call MHN or have your Participating Provider call us and we will make a referral to another Participating Provider.

Continuity of Care

New Members: If your Employer or Group has changed health plans and you were receiving services from a non-Participating Provider for a current episode involving an acute, chronic or serious mental health condition, MHN may, if certain other criteria are met, authorize continuing services from your non-Participating Provider. This decision is determined by MHN, in consultation with the Member and the non-Participating Provider, and consistent with good professional practice. If authorized, MHN will provide a reasonable transition period for you to continue your course of treatment with the non-Participating Provider prior to transferring to a Participating Provider.

Among other limitations, new member continuity of care services do not apply if you were offered and refused an out-of-network option by your Employer or Group, or if you had the option to continue with your previous health plan or non-Participating Provider and instead voluntarily chose to change health plans, or if the non-Participating Provider does not agree to abide by the terms and conditions contained in MHN's standard participating provider contract.

If you feel that you are in need of continuity of care services or if you would like a copy of MHN's new member continuity of care policy, please contact MHN at 1-800-777-9355.

Members Whose Provider's Contract Has Been Terminated or Not Renewed: If you are receiving care for an acute or serious chronic condition and your Participating Provider's contract is terminated or not renewed, you may call MHN at the telephone number in this booklet and request continuing care by your Participating Provider for Medically Necessary Services, provided you are still eligible. Continuing care may be provided for up to 90 days or longer if necessary for an appropriate transition to a Participating Provider. This decision is determined by MHN, in consultation with the terminated provider, and consistent with good professional practice.

MHN may require the terminated provider whose services are continued beyond the contract termination date to agree in writing to be subject to the same contractual terms and conditions that were in effect prior to termination. This includes, but is not limited to rates, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.

If the terminated provider does not agree to comply or does not comply with MHN's contractual terms and conditions, MHN will not be obligated to continue the provider's services beyond the contract termination date. Further, if the terminated provider voluntarily terminates his or her contract, MHN is not obligated to continue the provider's services beyond the contract termination date.

Your copayments, deductibles, or other cost-sharing components during the period of continuation of care with a terminated provider will be the same amount that you would have paid when receiving care from a currently contracted Participating Provider. Your provider must agree to accept MHN reimbursement as payment in full for Covered Services.

MHN will not provide continuing care by a provider whose contract with MHN has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code, fraud or other criminal activity.

MHN also will not cover services or provide benefits that are not otherwise covered under the terms and conditions of this Plan.

Provider Compensation

Generally, MHN compensates its Participating Providers on a fee-for-service basis. MHN does not compensate Participating Providers with bonuses or financial incentives related to the amount of services you may receive under this Plan.

Other Things to Know

The Independent Contractor Relationship

The relationship between MHN and Participating Providers is that of an independent contractor. Participating Providers are not agents or employees of MHN, nor is MHN and/or its employees and agents an employee or agent of any Participating Provider. MHN and its Participating Providers are not authorized to represent each other for any purposes, nor are they or any of their respective officers, agents or employees to be construed to be officers, agents or employees of the other. Participating Providers maintain the provider-patient relationship with Members and are solely responsible to Members for all services they provide to Members. In no event shall MHN be liable for the negligence, wrongful acts or omissions of Participating Providers.

MHN and your Employer or Group are independent contractors in relation to one another and no joint venture, partnership, employment, agency or other relationship is created by the Agreement. Neither MHN nor your Employer or Group are liable for any act, negligence or omission of the other, nor are they each other's agents or employees. Neither MHN nor your Employer or Group is authorized to represent the other for any purpose. None of the parties to the Agreement nor any of their respective officers, agents or employees shall be construed to be the officer, agent or employee of any other party.

Non-Assignability of Benefits

Members cannot transfer the coverage and benefits of this Plan to another person without the prior written consent of MHN. Such a request may be denied for any reason. MHN reserves the right to make payment of benefits, at its sole discretion, directly to the Participating Provider or to the Member.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which MHN Services (“MHN”) (referred to as “we” or “the Plan”) may collect, use and disclose your protected health information and your rights concerning your protected health information. “Protected health information” is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

- **Payment.** We use and disclose your protected health information in order to pay for your covered health coverage or expenses. For example, we may use your protected health information to process claims, to be reimbursed by another insurer that may be responsible for payment or for premium billing.
- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, pharmacies, hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** If you are enrolled through a group health plan, we may provide non-identifiable summaries of claims and expenses for enrollees in your group health plan to the plan sponsor, which is usually the employer.

If the plan sponsor provides plan administration services, we may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. MHN will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who’s involved with your care or payment. We may

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

OTHER PERMITTED OR REQUIRED DISCLOSURES

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

OTHER USES OR DISCLOSURES WITH AN AUTHORIZATION

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have certain rights regarding protected health information that the Plan maintains about you.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions.

Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.

- **Right To Amend Your Protected Health Information.** If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.
- If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.
- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

- **Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. *We may not agree to your request.* If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
- **Right To Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.

HEALTH INFORMATION SECURITY

MHN requires its employees to follow the MHN security policies and procedures that limit access to health information about members to those employees who need it to perform their job responsibilities. In addition, MHN maintains physical, administrative and technical security measures to safeguard your protected health information.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our website at www.mhn.com. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the privacy office listed at the end of this Notice. We support your right to protect the privacy of your protected health information. ***We will not retaliate against you or penalize you for filing a complaint.***

CONTACT THE PLAN

If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, please contact:

MHN
Legal Department
1600 Los Gamos Drive, Suite 300
San Rafael, CA 94903
(800) 533-3719, ext. 7232