

EMPATHIA

Employee Assistance Program (EAP)

Combined Evidence of Coverage and Disclosure Form

(EXHIBIT A OF SPECIALIZED HEALTH CARE SERVICE PLAN CONTRACT)

**PLEASE READ THE FOLLOWING INFORMATION
SO YOU WILL KNOW FROM WHOM
YOUR EAP SERVICES MAY BE OBTAINED**

Your employer has chosen Empathia Pacific, Inc. (Empathia) to provide Employee Assistance Program [EAP] services. All EAP services covered under this Plan will be provided by Empathia EAP Providers.

Empathia Pacific, Inc. is a private national firm specializing in employee assistance programs. Empathia is not an insurance company.

This Evidence of Coverage and Disclosure Form constitute only a summary of your plan Benefits. The Empathia Employee Assistance Program Subscriber Contract (the contract between your Employer and Empathia) must be consulted to determine the exact terms and conditions of coverage.

Any questions? Call our Member Services Department at 800-367-7474

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**COMBINED EVIDENCE OF COVERAGE
AND DISCLOSURE FORM**

**WELCOME TO EMPATHIA PACIFIC, INC.
EMPLOYEE ASSISTANCE PROGRAM**

Your employer has chosen Empathia Pacific, Inc. (Empathia) to provide Employee Assistance Program [EAP] services for you, your dependents and other members living in your home. Empathia Employee Assistance Program (the “Plan”) is a specialized health care service plan licensed in California under the Knox Keene Act. This brochure is your COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM. Your employer has entered into a contract with the Plan.

This Combined Evidence of Coverage and Disclosure Form provides you with important information on how to obtain Covered Services and the circumstances under which Benefits will be provided to you. **PLEASE READ IT CAREFULLY.**

Keep this publication in a safe place where you can easily refer to it when you are in need of Covered Services.

**Empathia Pacific, Inc.
Employee Assistance Program
5234 Chesebro Road, Suite 201
Agoura Hills, CA 91301
(800) 367-7474**

Web site: www.mylifematters.com

**INTRODUCTION TO
EMPATHIA PACIFIC, INC.
EMPLOYEE ASSISTANCE PROGRAM**

Empathia Pacific, Inc. (Empathia) - Employee Assistance Program is a Specialized California Health Care Service Plan headquartered in Agoura Hills, California.

When you receive Covered Services from an EAP Provider, you will not be responsible for paying any Co-Payment. You will not make Premium payments; your employer makes Premium payments on your behalf.

If you wish to know more information about any of the issues covered in this Combined Evidence of Coverage/Disclosure Form, you may request additional information from the Plan. Also if you have any questions or concerns about Empathia Employee Assistance Program, call our Member Services Department at the telephone number provided below. Our Member Services Officer will be happy to assist you.

The Plan, operating as a specialized health care service plan, will provide you an appropriately qualified and licensed behavioral health care Provider, acting within the scope of EAP practice, and who possesses a clinical background, including training and expertise related to the delivery of employee assistance program services.

**Empathia Pacific, Inc.
Employee Assistance Program
Member Services Department
5234 Chesebro Road, Suite 201
Agoura Hills, CA 91301**

Telephone: (800) 367-7474

IMPORTANT TERMS

The following definitions apply to this Combined Evidence of Coverage and Disclosure Form:

BENEFITS means those Covered Services an Enrollee is entitled to receive under the applicable Empathia Pacific, Inc. Specialized Health Care Service Plan Contract.

BENEFIT PERIOD means a period identified by the Specialized Health Care Service Plan Contract (usually twelve months), which serves to limit your Covered Services for that period of time.

COBRA means Consolidated Omnibus Budget Reconciliation Act of 1985 for continued access to health insurance coverage to be provided to Enrollees, and their dependents, of Subscribers with 20 or more eligible Enrollees.

COMBINED EVIDENCE OF COVERAGE/DISCLOSURE FORM (EOC/DF) means the certificate, agreement, contract, brochure, or letter of entitlement issued to a Subscriber/Enrollee setting forth the coverage to which the Subscriber or Enrollee is entitled.

COMMUNITY SERVICES are defined as qualified long-term behavioral health and/or chemical dependency treatment resources. Community Services are not included under this specialized health care plan.

CO-PAYMENT means the amount, if any specified herein, which represents the Enrollee's portion of the cost of Covered Services. There are no Co-Payments required of any Enrollee.

COVERED SERVICES means those services an Enrollee is entitled to receive under the Plan.

CRISIS INTERVENTION means the process of responding to a request for immediate services in order to determine whether or not a medical-psychiatric emergency or urgent situation exists and to otherwise assess the needs for short term counseling, referrals to community resources and/or referrals to medical psychiatric services.

EFFECTIVE DATE means the actual calendar date when your Specialized Health Care Service Plan Contract becomes effective. This date is found on Page 1, line 1 of the Subscriber Contract.

EMERGENCY MEDICAL CONDITION means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES includes medical screening, examination and evaluation by a physician, or other appropriate Providers under the supervision of a physician to determine if an Emergency Medical Condition exists, and if it does, the care, treatments, and surgery by a physician necessary to relieve or eliminate the Emergency Medical Condition. Emergency Services also include screening examination and evaluation by an MD psychiatrist, physician or other applicable Providers within the scope of their licenses to determine if a psychiatric medical

condition exists and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition.

ENROLLEE means an employee of the Subscriber organization, their eligible dependents and significant others who are permanent residents of the Enrollee's household are eligible for services under the Plan. Any minor child or spouse/former spouse who does not permanently reside with the Enrollee and is ordered by the court that coverage be provided, is also eligible under the Plan.

EMPLOYER means an organization that has contracted with the Plan to provide employee assistance services to its eligible employees and who is responsible for payment to The Plan.

EXCLUSIONS mean services that are not covered under the Plan.

FRAUD means the deliberate submission of false information by a Provider, Subscriber, Plan Enrollee, Plan employee or other individual or entity, to gain an undeserved payment on a claim or false information relating to the number of Enrollees covered under the Subscriber Contract with the Plan or false information relating to making formal management referrals or deceptive practices that violate the confidentiality of the Enrollee and demands for confidential Enrollee information that would violate federal and state law governing confidentiality and professional codes of ethics for employee assistance program services Providers, and mental health professionals.

GRIEVANCE means a written or oral expression of dissatisfaction regarding the Plan and/or a Provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an Enrollee or the Enrollee's representative. Where the Plan is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

LIMITATION means the maximum number of EAP counseling sessions an Enrollee is eligible to receive under the Subscriber Contract for each problem.

PREMIUM means the sum of money paid monthly to the Plan that entitles the Enrollee to receive the Covered Services provided by the Plan (Empathia Employee Assistance Program) as outlined in this Evidence of Coverage and Disclosure Form.

PROVIDER means a clinical psychologist (PhD), licensed clinical social worker (LCSW), marriage family and child therapist (MFT), or certified addictions counselor (CAC) who provides EAP assessment, referral and short-term counseling services to Enrollees under the Plan.

SESSION means an outpatient visit with a Provider conducted on an individual basis during which counseling services are delivered.

SPECIALIZED HEALTH CARE SERVICE PLAN CONTRACT means a contract for health care services in a single specialized area of health care, for Subscribers or Enrollees, or which pays for or which reimburses any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the Subscribers or Enrollees.

SUBSCRIBER means the entity that is responsible for payment to the Plan. The employer organization contracting with the Plan for EAP services is responsible for payment to the Plan.

OBTAINING YOUR EAP BENEFITS

Please read the remainder of this Combined Evidence of Coverage and Disclosure Form to fully understand how to use your Empathia Employee Assistance Program Benefits. Here are the basics:

- For confidential assistance, call the toll free EAP Help Line number 24 hours a day.
- An EAP Help Line professional will take your information, assess your situation, and use that information to find the appropriate Provider in the area close to your home or work, as you prefer it.
- The information is given to the Provider who then gives you a call to set up an in-person appointment at the Provider's office.
- On the initial appointment, an assessment is made to determine if short-term counseling is appropriate or if a referral to Community Services is needed to resolve your situation/problem.
- The EAP Provider must consult with the Plan's Clinical Director or Assistant Clinical Director who will review each request for Sessions beyond the assessment to ensure the assessment clearly indicates that short-term counseling is clinically appropriate to assist the Enrollee in resolving their issues. Any request that is clinically appropriate for short-term treatment will be approved up to the maximum number of Sessions contracted for in the EAP plan model the Subscriber has contracted for

Such approvals or denials will be given to the EAP Provider within forty-eight (48) hours, or two (2) business days. If the assessment does not indicate that short-term treatment is appropriate, the request will be denied and the Clinical Director or Assistant Clinical Director will provide the basis of denial both telephonically and in writing, and will assist the Provider as necessary to provide the Enrollee an appropriate referral beyond EAP for counseling or treatment.

PRINCIPAL BENEFITS AND COVERAGE

This section summarizes the Covered Services provided to Enrollees, their dependents and household members.

The services offered by the EAP include problem assessment, short-term counseling, referral and follow-up. Formal medical diagnoses or on-going treatment services are not provided. The EAP services provided to you may include referring you to independent resources for on-going assistance. If a referral is made, the EAP will usually provide two or three resource options; the final choice will be your responsibility. These referrals are made in consideration of our assessment of your needs. The EAP receives no reimbursement from any referral source.

If a referral for on-going treatment services is required, your EAP Provider will consider your insurance Benefits and ability to pay, and will discuss these matters with you. However, you are responsible for final verification of insurance coverage and any Co-Payments or charges not covered by your insurance. The Plan provides clinical assessment, short-term counseling and referral for a variety of problems including, but not limited to.

- o Marital or Relationship Difficulties
- o Family and Child Problems
- o Stress/Anxiety
- o Depression
- o Grief and Loss
- o Substance Abuse
- o Domestic Violence
- o Job Performance Issues
- o Crisis Intervention
- o Communication and/or Conflict Issues
- o Weight and eating disorders

Referrals are provided to Enrollee to community resources for any ongoing assistance in these areas. Services by a community resource are not Covered Services.

When the Plan refers an Enrollee to community resources for assistance for non-Covered Services, the Enrollee is responsible for payment of costs and fees for services provided by community resources that are not contracted Providers.

Limitation

Enrollees may receive up to 3 EAP counseling sessions for each problem specified in the Subscriber Contract.

Choice of Providers

These services to Enrollees are based in EAP core technology as defined by the U. S. Department of Health and Human Services and the International Employee Assistance Professionals Association, regardless of the educational background and licensure level of the Provider. Listed services are provided through Providers who have agreed to enter into a written contract with Empathia Pacific, Inc.

- (a) All contracting Providers are appropriately licensed and/or certified qualified clinical professionals who function as EAP counselors within the scope of employee assistance services and shall comply with professionally recognized standards of practice and all applicable state and federal laws.
- (b) EAP Providers may be licensed as Marriage Family and Child Therapists (MFT), Licensed Clinical Social Workers (LCSW), Clinical Psychologists (PhD), and Certified Addictions Counselors (CAC). All perform EAP counseling within the defined scope of EAP services.

A list of contracting providers within the Enrollee's general geographic area is available upon request.

The Plan will provide EAP services to Subscriber's employees, hereafter referred to as eligible Enrollees, at times and locations(s) agreed to and arranged by the Plan and Enrollee.

You may request a different EAP Provider for assessment and referral and/or short-term counseling for second opinion at no cost to you, by contacting the Member Services Officer at 800/367-7474. Requests for a second opinion by an Enrollee will be authorized or denied in a timely manner, appropriate to the nature of the Enrollee's condition, and will be provided in a time period not to exceed 72 hours after the Plan's receipt of the request. The second opinion will be given by a licensed health care Provider who is acting within his/her scope of practice, and who possess a clinical background related to the condition associated with the Enrollees request. This second opinion will be given, without cost to the Enrollee.

Continuity of Care

- Terminated Providers

Should the Subscriber, Provider, or the Plan terminate its contract, the Plan will provide Enrollees continuity of care for assessment and referral, or short-term counseling services. The Plan will complete all assessment and referral services and/or remaining short-term counseling which have been started prior to the date of termination and that are clinically appropriate. The Plan will provide you sixty (60) days written notice of termination of any contracting EAP Provider if you may, or would, be materially and adversely affected by such termination.

- New Employee

The Plan will allow any new Enrollee involved in a current episode of short-term counseling with a prior employee assistance program (EAP) service Provider, at the time their employer terminated the prior EAP contract, to continue in short-term counseling with that Provider under the former plan, up to the limits of the number of short-term counseling Sessions to be provided by the Plan under the new Subscriber Contract. The Plan will not attempt to offer continuity of care beyond the scope of employee assistance services and its licensed capabilities.

Facilities

Enrollees may obtain a list of EAP Providers in their geographic area by calling the Plan at 1-800-367-7474, or by submitting a request to the Plan. All requests for services must be coordinated by contacting the Plan through the 24 hours/day, 7 days/week toll-free EAP Help Line at 1-800-367-7474.

Obtaining Emergency Services

In the event that an Enrollee is having or believes that he/she is having a medical or psychological emergency, the Enrollee or dependent should call 911 or go to the nearest hospital emergency room. Medical/psychiatric emergencies and services for medical emergency or other medical/psychiatric care are not Covered Services and will not be paid by the EAP.

Enrollees are encouraged to use appropriately the "911" emergency response system, in areas where the system is established and operating, when they have, or believe they have, an emergency psychiatric or medical condition that requires an emergency response.

Crisis Intervention

Your EAP provides 24-hour telephone Crisis Intervention. The EAP will determine whether or not to provide appropriate intervention, as well as assess the need for short-term counseling, referrals to community resources or referrals for emergency behavioral care and treatment.

Where there is no Crisis, but the Enrollee or dependent has an urgent need to see a Provider within 48 hours to address a serious problem or condition, the EAP will schedule the Enrollee with a Provider who will offer an appointment within this time frame.

EXCLUSIONS

The following services are specifically excluded:

- All services other than the Employee Assistance Plan services covered on page 6.

The following services are specifically excluded from Covered Services:

- (a) Aversion Therapy
- (b) Biofeedback and hypnotherapy
- (c) Court-ordered services required as a condition of parole or probation
- (d) Services for remedial education including evaluation or treatment of learning disabilities or minimal brain dysfunction; developmental and learning disorders; behavioral training; or cognitive rehabilitation
- (e) Treatment or diagnostic testing related to learning disabilities, developmental delays, or educational testing or training
- (f) Services received from a non-contracting Provider, unless The Plan provides prior approval
- (g) Psychological testing
- (h) Examinations and diagnostic services in connection with the following: obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; securing insurance coverage; foreign travel or school admissions
- (i) Services of a psychiatrist (M.D.), including medication management or medication consultation
- (j) Prescription drugs
- (k) Inpatient, Outpatient, or Residential services for behavioral health or substance abuse treatment
- (l) Services for which the Subscriber promotes use through monetary or other material incentives or rewards offered or provided to Enrollees who use or are encouraged to use such services.

ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND RENEWAL PROVISIONS

Eligibility

To be eligible for services under the Plan, your employer must have executed a Specialized Health Care Service Plan Contract (“Subscriber Contract”) with Empathia Employee Assistance Program.

Your employer makes the determination of who is eligible to participate and who actually participates in the Plan. Disputes or inquiries regarding eligibility, including rights regarding renewal, reinstatement and the like may be referred by Empathia Employee Assistance Program to your employer for determination.

If an Enrollee is terminated from employment and he or she returns to active employment with Subscriber, such Enrollee and his or her eligible dependents may again become eligible.

Dependent coverage is included in the Plan. Dependent is defined as follows:

1. The lawful spouse of the Enrollee. All newborn infants whose eligibility begins from and after the moment of birth. Adopted children, stepchildren, and foster children are eligible from and after the date of placement. Except as stated above, dependents are eligible for coverage on the date the Enrollee is eligible for coverage or on the day the Enrollee acquires such dependent.
2. An Enrollee's dependent, up to age twenty-six (26), irrespective of the dependent's place of residence, marital, financial, or student status.
3. Coverage will not terminate while a dependent child is and continues to be (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (2) chiefly dependent upon the Enrollee for support and maintenance provided the Enrollee furnishes proof of such incapacity and dependency to Empathia Pacific, Inc., Employee Assistance Program within thirty (30) days of the child attaining the limiting age set forth in paragraph 2 above, and every two (2) years thereafter, if requested by the Plan.
4. In addition to the above, all permanent residents of the Enrollee's household are eligible for Covered Services under the Plan. Any spouse/former spouse who does not permanently reside with the Enrollee and is ordered by the court that coverage be provided is also eligible.

Enrollment

As an employee of your company, you and all persons who reside with you on a non-commercial basis are automatically eligible for coverage in the Empathia Employee Assistance Program. Any minor child or spouse/former spouse who does not permanently reside with you and is ordered by the court that coverage be provided is also eligible for services.

Effective Date of Coverage

The beginning of eligibility coverage is determined by the effective date of the Specialized Health Care Service Plan Contract. From that date forward, you must receive all EAP services through the Empathia Employee Assistance Program in order to maximize your Benefits.

Renewal Provisions

The Plan shall have a term of 6 months and shall automatically renew on the same terms and conditions for annual periods of 12 months at the end of the initial term and each renewal term unless either the Plan or Subscriber gives the other notice of termination not less than thirty (30) days before the end thereof. An addendum to the Subscriber Contract will be mailed to the employer if a change is approved.

CONFIDENTIALITY AND RELEASE OF INFORMATION

The Plan will maintain the confidentiality of all Enrollee EAP records except to the extent that disclosure is authorized by the Enrollee in writing, or is otherwise mandated by federal and state law. All EAP case records are maintained in compliance with all federal and state laws protecting the confidentiality and security of EAP records. The Plan maintains a comprehensive standard procedure on the confidentiality of case records that prescribes how Enrollee case records are to be maintained.

The Plan's procedures are also fully compliant with the Federal Health Insurance Portability & Accountability Act [HIPAA] that became effective April 14, 2003.

The Plan's Notice of Privacy Practices, which describes the Plan's policies and procedures for preserving the confidentiality of medical records, will be offered to each enrollee during the EAP intake call or counseling appointment. Members may request a paper copy of this Notice at any time by contacting the Plan at 1-800-367-7474. The Plan's Notice of Privacy Practices is also available on the Plan's member website at mylifematters.com

ANTI-DISCRIMINATION NOTICE

The Plan will never refuse to (i) enter into any Subscriber Contract, cancel or decline to renew or reinstate any Subscriber Contract, or (ii) enroll any person or accept any person as a Enrollee or renew any person as a Enrollee on the basis of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, or disability of any contracting party, prospective contracting party, or person reasonably expected to benefit from that contract as a Subscriber, Enrollee, member, or otherwise.

ANTI-FRAUD PLAN

The Plan has established an Anti-Fraud Plan to identify and reduce the risk and potential costs to the Plan, and to protect its EAP Providers, Subscribers, and their Enrollees, in the delivery of employee assistance services through the timely detection, investigation and prosecution of suspected fraudulent activities

Subscribers and their Enrollees should file a report of suspected or alleged fraudulent activities to the Plan. This filing of any report will be treated confidentially and should be filed with the Plan's Chief Executive Officer, who can be contacted by mail at 5234 Chesebro Road, Suite 201, Agoura Hills, California 91301 or by telephone at 1-818-707-0544 or by fax at 1-818-707-0496.

Any report of suspected or alleged fraudulent activities will be immediately investigated according to the Plan's published Anti-Fraud Plan S-00-08. Copies of the Anti-Fraud Plan are available upon request through the address and contact numbers listed above.

ORGAN DONATION

Organ Donation Notice: There is a need for organ donors across the country. You can agree to have your organs donated in the event of your death. If you wish to become an organ donor or tissue donor, tell your family members that you have decided to become an organ and tissue donor so they will understand your wishes and support them. Have a frank discussion about the steps they will need to take at the time of your death to ensure your donations take place in the proper time frame. If you wish to become an organ and tissue donor, the California Department of Motor Vehicles (DMV) can give you a donor card that you carry with your driver's license or I.D. card, and a donor sticker to place on the front of your driver's license or I.D. card and carry it in your wallet or purse at all times. Have two people witness your signature, preferably family members. For more information you can contact the National Transplant Society/National Donor Registry on-line at www.organdonor.org, or by contacting U. S. Department of Health and Human Services website at www.organdonor.gov.

TERMINATION OF BENEFITS

In most cases, your coverage will end when the Plan's contract with your employer [Subscriber] terminates. There are also some circumstances when your coverage may end even though the Plan's contract with your employer remains in effect, for example, when you are no longer eligible to receive EAP Benefits as an Enrollee [employee or family member], or the Plan no longer wants to provide services to you because of your conduct as described below.

Your coverage cannot be cancelled because of your health status or your use of EAP services. If you believe this has happened you may send us a written complaint to the attention of the Member Services Officer as described in the "Compliant, Grievance and Appeals Procedure" section of this Evidence of Coverage / Disclosure Form, or on-line at www.mylifematters.com, or by calling **1-800-367-7474**, asking to speak with the Member Services Officer. You may also request a review by the Director of the California Department of Managed Health Care.

- ❑ ***Termination by your employer [Subscriber]*** - Subscriber shall have the option to terminate this contract upon thirty (30) days written notice to the Plan, which notice shall specify concerns and/or complaints expressed by employees or Enrollees regarding use of the services, and which concerns and/or complaints shall not be resolved by the Plan to Subscriber's satisfaction during such sixty day notice period.
- ❑ ***Termination by the Plan of contract with Subscriber for non-payment*** – If your employer (Subscriber) fails to pay our fees, the Plan may terminate the Subscriber Contract for nonpayment. The Plan will first give your employer not less than thirty (30) days notice of our intent to terminate the Subscriber Contract for nonpayment. If payment is not received within those thirty (30) days, we will terminate the contract; wherein your employer will furnish you notice of the termination. Your coverage will terminate fifteen (15) days after your employer provides notice to you.
- ❑ ***Termination of coverage based on your conduct*** – The Plan reserves the right to cancel your coverage for Fraud or deception in the use of EAP services. "**Fraud**" means knowingly making, or causing, or permitting to be caused false statements in order for you or another person to obtain EAP services to which you or the other person is not entitled. "Fraud" also includes any act that constitutes Fraud under applicable federal or state law. Cancellation is effective immediately on the date you receive notice of cancellation.
- ❑ The Plan also reserves the right to cancel your coverage based on your conduct, if you threaten the safety of Plan employees, its EAP Providers, or others eligible for or receiving EAP services, or if your repeated behavior has substantially interfered with the Plan's, or its EAP Provider's ability to furnish or arrange services for you or others. Termination is effective fifteen (15) days after notice is sent to you.

- **Review by Department of Managed Health Care** – If Subscriber alleges that its contract for EAP services has been cancelled or not renewed because of the requirements for health care services, the Subscriber may request a review by the Director of the Department of Managed Health Care. If the Department of Managed Health Care determines that a proper complaint exists under the provisions of this section, the Director shall notify the Plan. Within 15 days after receipt of such notice, The Plan shall either request a hearing or reinstate the Subscriber.

The Plan does not engage in retroactive termination, and as an Enrollee [employee or eligible family member] under your employer’s Subscriber Contract, you will not be held retroactively responsible for any services provided to you by the Plan.

INDIVIDUAL CONTINUATION OF BENEFITS

Electing COBRA Coverage

Your employer is responsible for providing you notice of your right to receive continuing coverage under COBRA. Your employer is responsible for notifying the Plan of the duration of your eligibility.

If you terminate your employment with the Subscriber, you may not elect to continue your EAP benefit through your employer under COBRA.

LIABILITY OF SUBSCRIBER OR ENROLLEE FOR PAYMENT

Co-Payment

There are no Co-Payments. All Covered Services are paid for by the Plan.

Prepayment of Fees

Your employer is paying the monthly Premium for your EAP services. Neither you nor your dependents and other members of your household have any responsibility for payment of any Premiums or Co-Payments for EAP services provided to you under the Plan.

There are no restrictions on assignment of Benefits payable to the Enrollee by the Plan.

Reimbursement Provisions

All EAP services are 100% paid for by your employer under the Subscriber Contract it maintains with the Plan. Under the terms of the Subscriber Contract, Enrollees are required to access all EAP services through the Plan’s nationwide toll free EAP HelpLine, 1-800-367-7474, available to Enrollees 24 hours/day, 7 days/week.

In the rare case that an Enrollee might have to access EAP services through a Provider who is not contracted with the Plan due to the Plan's inability to offer the Enrollee access to a contracted Provider within the accessibility and time limits specified in the Plan's standards of accessibility, the Enrollee can request reimbursement from the Plan for any out-of-pocket payment for services incurred. Any such claim for reimbursement should be submitted to the Plan, Attention: Member Services Officer, at 5234 Chesebro Road, Suite 201, Agoura Hills, California 91301. Claims can also be submitted via fax at (818) 707-0496, Attention: Member Services Officer.

The Plan will evaluate the claim for reimbursement and notify the Enrollee within 15 days of the receipt of the claim of the approval or denial of the claim. If the claim is denied, the Plan will, during the same 15-day period, provide the Enrollee with information about the basis for denial and how to appeal the decision. If the claim for reimbursement is approved, payment will be made within 30 days from the date of receipt of the request for reimbursement.

This provision does not alter the Enrollee's requirement to access EAP services through the Plan's nationwide toll free EAP HelpLine, 1-800-367-7474, available to Enrollees 24 hours/day, 7 days/week.

Liability for Sums Owed by Empathia Pacific, Inc. Employee Assistance Program

California law requires that every contract between a Plan and a Provider must contain a provision that prohibits the Plan from holding you financially responsible for sums owed to a Provider by the Plan. Therefore, in the event the Plan fails to pay a Provider for Covered Services, you will not be liable to that Provider for the amount owed by the Plan.

How Empathia Pacific, Inc. Compensates EAP Providers

The Plan will pay each of the contracting EAP Providers directly for Covered Services on a negotiated fee-for-service basis.

Empathia Employee Assistance Program does not pay financial bonuses or other incentives to Plan Providers. Should you wish to know more about these issues, please contact our Member Services Department at 1-800-367-7474.

Providers are allowed to self-refer for continuing services beyond the scope of EAP services in specific situations in which the clinical need is best served by the Member remaining with the Provider for ongoing treatment services. In such cases, the Member will be asked to sign a Freedom of Choice Affidavit, which clarifies that the Member has been offered at least two alternative treatment resources and chooses to enter into a direct payment agreement with the Provider and that these treatment services are not covered under the Plan's EAP.

COMPLAINT, GRIEVANCE AND APPEALS PROCEDURES

Complaint/Grievance Process

Empathia Employee Assistance Program has established a Grievance process for receiving and resolving Enrollee complaints or Grievances with Empathia Employee Assistance Program and its contracted EAP Providers. If you should have any problem with services delivered through Empathia, the Empathia Member Services Department should be able to assist you and resolve those problems.

A Member Services Officer reviews any complaint involving care that has been received or denied. In the case of a denial, the reviewer will not have been involved in the initial denial of services.

The Member Services Officer will advise the Enrollee that the Plan will acknowledge in writing receipt of the Grievance within five (5) calendar days and will provide written resolution of the Grievance within (30) calendar days of receipt.

If a Grievance requires urgent attention, the Plan shall expedite its review of the Grievance to be resolved no less than three calendar days of receipt of Grievance.

You may file a complaint by phone, in writing, or online @ www.mylifematters.com. Our toll-free number is **1-800-367-7474**. Please ask to speak to the Member Services Officer, or address your correspondence to:

Empathia Pacific, Inc.
Employee Assistance Program
Attention: Member Services Officer
5234 Chesebro Road, Suite 201
Agoura Hills, CA 91301

Neither the Plan nor any of its participating providers will discriminate against an Enrollee based on the filing of a Grievance. If you believe that you have been discriminated against due to your filing a Grievance, please call 1-800-367-7474 and ask to speak to the Member Services Officer.

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a Grievance against your health plan, you should first telephone your Plan at **1-800-367-7474** and use The Plan's Grievance process before contacting the Health Plan Division for assistance. The Member Services Department is available to assist Enrollees with any complaints and Grievances. Utilizing this Grievance procedure does not prohibit any

potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your health plan, or a Grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

Public Policy Committee

The Plan has established a Public Policy Committee, with the majority of the committee members being from Subscriber groups who contract for the Plan's EAP services.

This committee meets at least quarterly and assists the Plan in establishing its public policy relating to services provided by the Plan, its Enrollees and contract Providers, to assure the comfort, dignity, and convenience of Enrollees seeking EAP services for themselves, their families and the public.

If you are interested in more information, please call us at 818/707-0544.