



*LifeMatters® 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**

The Employer has chosen Empathia Pacific, Inc. (Empathia) to provide LifeMatters Employee Assistance Program (EAP) services. All LifeMatters 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 LifeMatters Employee Assistance Program Subscriber Contract (the contract between the Employer and Empathia) must be consulted to determine the exact terms and conditions of coverage.

Any questions? Call our Member Services Department at (877) 828-3635

Table of Contents

Welcome to Empathia Pacific, Inc. (Empathia)	1
Introduction to LifeMatters EAP by Empathia	2
Important Terms	3-4
Obtaining Your LifeMatters EAP Benefits	5
Principal Benefits and Coverage	5-8
Limitation	6
Choice of Providers	6-7
Continuity of Care	7
Facilities	7
Obtaining Emergency Services	8
Crisis Intervention	8
Exclusions	8-9
Eligibility, Effective Date of Coverage, and Renewal Provisions	9-10
Eligibility	9-10
Effective Date of Coverage	10
Renewal Provisions	10
Confidentiality and Release of Information	10-11
Anti-Discrimination Notice	11
Anti-Fraud Plan	11
Organ Donation Notice	11
Termination of Benefits	12
Individual Continuation of Benefits	13
Electing COBRA Coverage	13
Liability of Subscriber or Enrollee for Payment	13-14
Co-Payment	13
Prepayment of Fees	13
Reimbursement Provisions	13-14
Liability for Sums Owed By Empathia Pacific, Inc. EAP	14
How Empathia Pacific, Inc. compensates EAP Providers	14
Complaint, Grievance and Appeals Procedures	15-16
Complaint/Grievance Process	15
Binding Arbitration	15-16
Review by the Department of Managed Health Care	16
Public Policy Committee	16

**COMBINED EVIDENCE OF COVERAGE
AND DISCLOSURE FORM**

**WELCOME TO EMPATHIA PACIFIC, INC.
LIFEMATTERS EAP**

The Employer has chosen Empathia Pacific, Inc. (Empathia) to provide LifeMatters Employee Assistance Program (EAP) services for you, your dependents and other members living in your home. Empathia Pacific, Inc. (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. The 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.
LifeMatters Employee Assistance Program
5234 Chesebro Road, Suite 201
Agoura Hills, CA 91301
(877) 828-3635

Website: www.mylifematters.com

INTRODUCTION TO LIFEMATTERS EAP BY EMPATHIA

LifeMatters Employee Assistance Program is provided by Empathia Pacific, Inc., 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; the 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 LifeMatters by 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.
LifeMatters Employee Assistance Program
Member Services Department
5234 Chesebro Road, Suite 201
Agoura Hills, CA 91301**

Telephone: (877) 828-3635

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 2, line 2 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 employee/family member of the employer organization and who is a recipient of services from 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 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 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.

SENSITIVE SERVICES means Covered Services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence.

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 an organization that has contracted with the Plan to provide employee assistance program to its eligible employee and is the entity that is responsible for payment to the Plan.

OBTAINING YOUR LIFEMATTERS EAP BENEFITS

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

- For confidential assistance, call the toll free EAP Help Line number 24 hours a day.
- A 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 Help Line professional will then provide you with the contact information for the Provider for you to call the Provider to schedule an appointment at the Provider's office.
- LifeMatters by Empathia will authorize the number of short-term counseling Sessions allowed under your EAP. The actual number of short-term counseling Sessions provided is a decision made between you and the Provider based on the Provider's assessment of your situation and goals for short-term counseling.
- At the initial appointment, an assessment is made by the Provider to determine if short-term counseling is appropriate, or if a referral to Community Services is needed to resolve your situation/problem.
- If the Provider determines that short-term counseling is appropriate, the Provider will help you evaluate and work toward resolving your problem. In many cases, problems can be resolved within the number of Sessions available through LifeMatters by Empathia.

PRINCIPAL BENEFITS AND COVERAGE

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

The services offered by LifeMatters by Empathia EAP include problem assessment, short-term counseling, referral and follow-up. Formal medical diagnoses or on-going treatment services are not provided. The 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 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 supportive counseling and referral for a variety of problems including, but not limited to.

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

The Plan will provide coverage for Covered Services appropriately delivered via telehealth modalities on the same basis and to the same extent that the Plan is responsible for coverage for the same Covered Services if delivered in-person.

Limitation

Enrollees may receive up to 8 counseling sessions for each problem specified in the Subscriber Contract.

Choice of Providers

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 program 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 services to Subscriber's employee, 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 (877) 828-3635. 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 the 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 program and its licensed capabilities.

Facilities

Enrollees may obtain a list of EAP Providers in their geographic area by calling the Plan at **(877) 828-3635**, 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 **(877) 828-3635**.

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 Program 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;
- (m) Services that are provided to an individual who is not an Enrollee based upon any misrepresentation of that individual's family relationship to an Enrollee.

ELIGIBILITY, EFFECTIVE DATE OF COVERAGE, AND RENEWAL PROVISIONS

Eligibility

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

The 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 the employer for determination.

If an Enrollee is terminated and he or she returns, such Enrollee and his or her eligible dependents may again become eligible.

Dependent coverage is included in the Plan. Dependent is defined as follows: the Enrollee's lawful spouse or registered domestic partner, or child. An Enrollee's dependent child includes the Enrollee's and/or the Enrollees' spouse's or registered domestic partner's: natural children, adopted children, stepchildren, children covered under a guardianship, and foster children.

1. All newborn infants whose eligibility begins from and after the moment of birth. Adopted children, stepchildren, children covered under a guardianship, 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. Coverage for an Enrollee's dependent child, 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 an Enrollee's dependent child is and continues to be (1) incapable of self-sustaining employment by reason of physically or mentally disabling injury, illness or condition ; 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 Specialized Health Care Plan Contract.

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 Specialized Health Care Plan Contract shall have a term of 12 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 ninety (90) 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 records, including those pertaining to Sensitive Services, and shall not disclose said records, except to the extent that disclosure is authorized by the Enrollee in writing or is otherwise mandated by federal and state law. All case records are maintained in compliance with all federal and state laws protecting the confidentiality and security of 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), and the California Confidentiality of Medical Information Act.

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 intake call or counseling appointment. Members may request a paper copy of this Notice at any time by contacting the Plan at **(877) 828-3635**. The Plan's Notice of Privacy Practices is also available on the Plan's member website at mylifematters.com

Confidential communications include bills, explanation of benefits, claims, information regarding a session, or other communications containing medical information, including information relating to Sensitive Services. The Plan will communicate confidential information to you by contacting you at the mailing address, email address, or telephone number on file, unless otherwise directed by you. If you would like to receive the Plan's confidential communications in a specific form and format and/or designate an alternative mailing address, email address, or telephone number, you may submit a request for confidential communications. You can make this request by contacting the Plan's Clinical Director via email at rhauser@empathia.com or by mail at:

Empathia Pacific, Inc.
c/o Clinical Director
5234 Chesebro Road, Suite 201
Agoura Hills, CA 91301

The Plan will acknowledge receipt of your confidential communications request and implement confidential communications requests within 7 calendar days of receipt of an electronic transmission or telephonic request or within 14 calendar days of receipt by first-class mail.

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

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, Employers, and their Enrollees, in the delivery of employee assistance program 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 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 Subscriber Contract with the Employer terminates. There are also some circumstances when your coverage may end even though the Plan's contract with the Employer remains in effect, for example, when you are no longer eligible to receive EAP Benefits as an Enrollee (employee or family member).

Your coverage cannot be cancelled because of your health status or your use of 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 (877) 828-3635, 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 the Employer*** – The Employer may terminate the Plan's contract at any time upon sixty (60) days written notice to the Plan, if the Plan is unable to resolve the employer's satisfaction concerns and/or complaints expressed by employee or Enrollees regarding use of the services.
- ❑ ***Termination by the Plan for non-payment*** – If the Employer fails to pay our fees, the Plan may terminate the Subscriber Contract for nonpayment. The Plan must first give the Employer a "Notice of Consequences for Nonpayment of Premiums" and a "Notice of Cancellation for Nonpayment of Premiums and Grace Period" before termination may take effect. The Employer is responsible to promptly provide enrollees with a copy of the Notice of Cancellation. Before any termination for nonpayment may occur, the Plan must provide a Grace Period of not less than thirty (30) days during which time your coverage will continue. If the Employer fails to pay a past due premium before the end of the Grace Period, the contract and your coverage will end after the end of the Grace Period.
- ❑ ***Termination of coverage based on other grounds*** – The Subscriber Contract permits the Plan to terminate the contract and your coverage on certain other grounds, such as an intentional misrepresentation of a material fact by the Employer in obtaining the Subscriber Contract. The Plan must first give the Employer a "Notice of Cancellation, Rescission or Nonrenewal" before termination may take effect. The Employer is responsible to provide a copy of this Notice of Cancellation to you promptly.
- ❑ ***Review by Department of Managed Health Care*** – In certain circumstances, the Employer will have the right to submit a Request of Review of any cancellation, rescissions or nonrenewal of the Subscriber Contract to the California Director of the Department of Managed Health Care. Depending on the outcome of such a review, the termination of the Subscriber Contract and your coverage may be delayed or may not take effect. In any event, the Employer is responsible to inform you of any termination of your coverage under the Subscriber Contract.

The Plan does not engage in retroactive termination, and as an Enrollee (employee or eligible family member) under the 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

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

If you terminate with the Employer, you may elect to continue your benefit through the Employer under COBRA. If you elect to continue this benefit, you are eligible for all services covered under the Subscriber Contract up to the limits of the Plan. You must notify the Employer that you elect to continue the benefit. The Employer will include your name on a list of employees who have selected the benefit under COBRA and will provide the Plan this updated list on a regular basis. You will not be responsible for filing a claim for EAP services under COBRA, as these services will continue to be paid by the Employer.

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

The 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 the Employer under the Subscriber Contract it maintains with the Plan. Under the terms of the Subscriber Contract, Enrollees are required to access all services through the Plan's nationwide toll free EAP Help Line, **(877) 828-3635**, available to Enrollees 24 hours/day, 7 days/week.

In the rare case that an Enrollee might have to access 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 Help Line, (877) 828-3635, 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 **(877) 828-3635**.

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 **(877) 828-3635**. Please ask to speak to the Member Services Officer, or address your correspondence to:

Empathia Pacific, Inc.
LifeMatters 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 **(877) 828-3635** and ask to speak to the Member Services Officer.

Binding Arbitration

All disputes that may arise between an Enrollee and the Plan, if they cannot be resolved informally shall be resolved by arbitration under the commercial rules of the American Arbitration Association (“AAA”). Therefore, any dispute, including any dispute as to medical malpractice, that is as to whether any medical or other services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, will be determined by submission to arbitration, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Enrollees, by accepting Covered Services, give up their constitutional right to have any such dispute decided in a court of law before a jury, and instead accept the use of arbitration.

For those disputes for which the total amount of damages claimed is \$200,000 or less, the parties shall select a single arbitrator who shall have no jurisdiction to award more than \$200,000. The arbitration shall take place in California and judgment upon any award rendered by the arbitrator may be duly entered in any court in the State of California, having jurisdiction thereof. The prevailing party shall be entitled to court costs and reasonable attorney's fees.

In case of financial hardship, the AAA may determine that you are not required to pay for the administrative costs of arbitration. The Plan will, upon request, provide you an application for relief from this requirement. If the AAA does not grant your request, the Plan shall, in cases of extreme hardship, assume all or part of your share of these administrative costs.

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 health plan at **1-877-828-3635** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by 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 website **www.dmhc.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**.



Aviso para solicitar comunicaciones confidenciales

Estimado/a [suscriptor o afiliado]:

De acuerdo con la ley de la legislatura de California 1184 (Chiu, Ch. 190, Stats. 2021), le escribimos para informarle que usted tiene derecho a solicitar comunicaciones confidenciales de nuestra parte en una forma y un formato específicos y/o designar una dirección postal, una dirección de correo electrónico o un número de teléfono alternativos por los cuales desea recibir las comunicaciones confidenciales. Las comunicaciones confidenciales incluyen facturas, explicación de beneficios, reclamaciones, información concerniente a una sesión u otras comunicaciones que contengan información médica, que incluye información relativa a salud mental o conductual, salud sexual y reproductiva, infecciones de transmisión sexual, trastorno por consumo de sustancias, atención para reasignación de sexo y violencia de pareja. Para comunicarle información confidencial, nos pondremos en contacto con usted en la dirección postal, la dirección de correo electrónico o el número de teléfono que tengamos registrados, a menos que usted indique otra cosa.

Si desea recibir comunicaciones confidenciales de nuestra parte en una forma y un formato específicos y/o designar una dirección postal, una dirección de correo electrónico o un número de teléfono alternativos, puede enviar una solicitud de comunicaciones confidenciales. Para hacer esta solicitud, comuníquese con nuestro Director Clínico por correo electrónico a rhauser@empathia.com o por correo postal a:

Empathia Pacific, Inc.
c/o Clinical Director
5234 Chesebro Road, Suite 201
Agoura Hills, CA 91301

Acusaremos recibo de su solicitud de comunicaciones confidenciales e implementaremos las solicitudes de comunicaciones confidenciales en un plazo de 7 días calendario desde la recepción de una solicitud telefónica o por transmisión electrónica o en un plazo de 14 días calendario desde la recepción de un correo de primera clase. Su solicitud de comunicaciones confidenciales será válida hasta que la revoque o presente una nueva solicitud de comunicaciones confidenciales.

Si tiene alguna pregunta o si desea recibir una copia actualizada de nuestro aviso de prácticas de privacidad, visite nuestro sitio web en [mylifematters.com] o llámenos al (800) 367-7474.

Atentamente,

Empathia Pacific, Inc.



Aviso para solicitar comunicaciones confidenciales

Estimado/a [suscriptor o afiliado]:

De acuerdo con la ley de la legislatura de California 1184 (Chiu, Ch. 190, Stats. 2021), le escribimos para informarle que usted tiene derecho a solicitar comunicaciones confidenciales de nuestra parte en una forma y un formato específicos y/o designar una dirección postal, una dirección de correo electrónico o un número de teléfono alternativos por los cuales desea recibir las comunicaciones confidenciales. Las comunicaciones confidenciales incluyen facturas, explicación de beneficios, reclamaciones, información concerniente a una sesión u otras comunicaciones que contengan información médica, que incluye información relativa a salud mental o conductual, salud sexual y reproductiva, infecciones de transmisión sexual, trastorno por consumo de sustancias, atención para reasignación de sexo y violencia de pareja. Para comunicarle información confidencial, nos pondremos en contacto con usted en la dirección postal, la dirección de correo electrónico o el número de teléfono que tengamos registrados, a menos que usted indique otra cosa.

Si desea recibir comunicaciones confidenciales de nuestra parte en una forma y un formato específicos y/o designar una dirección postal, una dirección de correo electrónico o un número de teléfono alternativos, puede enviar una solicitud de comunicaciones confidenciales. Para hacer esta solicitud, comuníquese con nuestro Director Clínico por correo electrónico a rhauser@empathia.com o por correo postal a:

Empathia Pacific, Inc.
c/o Clinical Director
5234 Chesebro Road, Suite 201
Agoura Hills, CA 91301

Acusaremos recibo de su solicitud de comunicaciones confidenciales e implementaremos las solicitudes de comunicaciones confidenciales en un plazo de 7 días calendario desde la recepción de una solicitud telefónica o por transmisión electrónica o en un plazo de 14 días calendario desde la recepción de un correo de primera clase. Su solicitud de comunicaciones confidenciales será válida hasta que la revoque o presente una nueva solicitud de comunicaciones confidenciales.

Si tiene alguna pregunta o si desea recibir una copia actualizada de nuestro aviso de prácticas de privacidad, visite nuestro sitio web en [mylifematters.com] o llámenos al (800) 367-7474.

Atentamente,

Empathia Pacific, Inc.

Thank you for being a LifeMatters by Empathia member. Please take a moment to read this important information about Empathia's Grievance Policies.

If you have a grievance regarding LifeMatters by Empathia services, you may contact us by phone, by mail, or on-line. We're open 24 hours a day, 7 days a week. We have a process in place for receiving and resolving all grievances regarding LifeMatters services.

Empathia Pacific, Inc.
LifeMatters
Attention: Member Services
5234 Chesebro Road, Suite 201
Agoura Hills, CA 91301

Toll-free 24/7: 1-800-367-7474
Online: [www.mylifematters.com]

A grievance is an expression of dissatisfaction expressed by you or your authorized representative through the grievance process. A grievance includes a complaint or an appeal.

You may submit a grievance in the following ways:

- By calling our toll-free 24/7 Help Line at **1-800-367-7474**. CRS TTY users call **711**.
- By mailing your written grievance to us at the address shown above
- By completing a grievance form at a LifeMatters provider's office
- By completing the grievance form on our website at [mylifematters.com]

If you need help submitting a grievance, please call our Member Services Center at **1-800-367-7474**.

LifeMatters staff members document grievances by completing a Client Complaint Entry Form. When a Client Complaint Entry Form is completed by a LifeMatters staff member, the form becomes part of an enrollee's Client Service record in Empathia's proprietary database, and an electronic notification is automatically sent to our Clinical Director, Member Services Officer, and Clinical Management team for tracking. All grievances are reviewed and investigated by Empathia's Clinical Director and Member Services Officer.

All grievances, except those that are resolved by the end of the next business day, are acknowledged in writing within five (5) calendar days of receipt of the grievance. Empathia is committed to resolving grievances within 30 days.

Grievances involving an imminent and serious threat to the health of an enrollee are handled on an expedited basis. Empathia will immediately inform the enrollee of their right to contact the California Department of Managed Health Care regarding the grievance. Empathia will submit a written statement to the enrollee and the Department on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance. Consideration will be made by Empathia of the enrollee's medical condition when determining the response time (as appropriate and within the clinical scope of practice). Empathia will inform the enrollee that there is no requirement that the enrollee participate in Empathia's grievance process prior to the

enrollee applying to the Department of review of the urgent grievance.

Grievances are reported on a quarterly basis to Empathia's Quality Management Committee, Board of Directors, and the Department of Managed Health Care.

Language Assistance Services

English: Language assistance services in your preferred spoken and written languages are available at no cost by calling **1-800-367-7474**.

Spanish: Para solicitar servicios sin costo de asistencia en sus idiomas preferidos, orales o escritos, puede llamar al **1-800-367-7474**.

CALIFORNIA RESIDENTS

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 health plan at **1-800-367-7474** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by 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 website **www.dmhca.gov** has complaint forms, IMR application forms and instructions online.

Gracias por ser un miembro de LifeMatters de Empathia. Tome un momento para leer esta información importante sobre las políticas de queja de Empathia.

Si tiene alguna queja respecto a los servicios de LifeMatters de Empathia, puede ponerse en contacto con nosotros por teléfono, por correo postal o por Internet. Estamos a su disposición las 24 horas al día, los 7 días de la semana. Tenemos un proceso para recibir y resolver todas las quejas relativas a los servicios de LifeMatters.

Empathia Pacific, Inc.
LifeMatters
Attention: Member Services
5234 Chesebro Road, Suite 201
Agoura Hills, CA 91301

Línea gratuita 24/7: 1-800-367-7474
En línea: www.mylifematters.com

Una queja es una expresión de insatisfacción expresada por usted o su representante autorizado a través del proceso de queja. Una queja incluye una reclamación o una apelación.

Puede presentar una queja de las siguientes maneras:

- Llamar a nuestra línea de ayuda gratuita 24/7 al **1-800-367-7474**. Llamar al **711** si es usuario de TTY del Servicio de Retransmisión de California [CRS].
- Enviarnos su información escrita a la dirección que se indica arriba.
- Completar un formulario de queja en la oficina del proveedor de LifeMatters
- Completar el formulario de queja de nuestro sitio web en **mylifematters.com**

Si necesita ayuda para presentar una queja, llame a nuestro Centro de Servicios para Miembros al **1-800-367-7474**.

Los miembros del personal de LifeMatters documentan lo siguiente relleno un Formulario de ingreso de queja del cliente.

Cuando un miembro del personal de LifeMatters completa un Formulario de ingreso de queja del cliente, el formulario pasa a formar parte de un registro de Servicio al Cliente del afiliado en la base de datos propiedad de Empathia, y se envía automáticamente una notificación electrónica a nuestro Director Clínico, al Responsable de Servicios para Miembros y al equipo de Gestión Clínica para su seguimiento. Todas las quejas son revisadas e investigadas por el Director Clínico y el Responsable de Servicios para Miembros de Empathia.

Se acusa recibo de todas las quejas, excepto aquellas que se resuelven a más tardar al final del siguiente día laborable, en un plazo de cinco (5) días naturales a partir de la recepción de la queja. Empathia se ha comprometido a solucionar las quejas en un plazo de 30 días.

Las quejas que impliquen una amenaza inminente y grave para la salud de un afiliado se procesan de forma urgente. Empathia informará de inmediato al afiliado de su derecho a ponerse en contacto con el Departamento de Atención de la Salud Administrada de California (California Department of Managed Health Care) en relación con la queja. Empathia enviará una

declaración por escrito al afiliado y al Departamento en el destino o pendiente de la reunión urgente en un plazo de tres (3) días naturales a partir de la recepción de la queja. Empathia tomará en cuenta el estado médico del afiliado a la hora de determinar el tiempo de respuesta (según corresponda y dentro del ámbito de la práctica clínica). Empathia informará al afiliado de que no existe ningún requisito de que el afiliado participe en el proceso de quejas de Empathia antes de que pueda solicitar al Departamento una revisión de la queja urgente.

Las quejas se comunican trimestralmente al Comité de Gestión de Calidad de Empathia, al Consejo de Administración y al Departamento de Atención de la Salud Administrada.

Servicio de asistencia lingüística

Inglés: Los servicios de asistencia lingüística en los idiomas hablados o escritos de su preferencia están disponibles sin costo alguno para usted llamando al **1-800-367-7474**.

Español: Para solicitar servicios sin coste de asistencia en sus idiomas preferidos, orales o escritos, puede llamar al **1-800-367-7474**.

RESIDENTES EN CALIFORNIA

Revisión del Departamento de Atención de la Salud Administrada

El Departamento de Atención de la Salud Administrada de California (California Department of Managed Health Care) es la entidad responsable de regular los planes de atención de la salud. Si tiene una queja contra su plan de salud, primero debe llamar a su plan de salud al **1-800-367-7474** y utilizar el proceso de quejas de su plan de salud, antes de comunicarse con el Departamento. El uso de este procedimiento de quejas no le impide hacer valer ningún derecho o recurso legal que podría estar disponible para usted. Si necesita ayuda con una queja relacionada con una emergencia, una queja que su plan de salud no ha resuelto satisfactoriamente o una queja que no se ha resuelto durante más de 30 días, puede llamar al Departamento para solicitar ayuda. También puede ser elegible para una Revisión médica independiente (Independent Medical Review, IMR). Si reúne los requisitos para una IMR, el proceso de IMR proporcionará una revisión imparcial de las decisiones médicas tomadas por un plan de salud relacionadas con la necesidad médica de un servicio o tratamiento propuesto, decisiones de cobertura para tratamientos que son de naturaleza experimental o de investigación y disputas de pago para servicios médicos de emergencia o urgentes. El Departamento también tiene un número de teléfono gratuito (**1-888-466-2219**) y la línea TDD (**1-877-688-9891**) para personas con impedimentos auditivos y del habla. El sitio web de Internet del Departamento **www.dmhca.gov** tiene formularios de quejas, formularios de solicitud de IMR e instrucciones en línea.