Claremont Behavioral Services

Employee Assistance Program (EAP)

Partnership HealthPlan of California

Combined Evidence of Coverage and Disclosure Form

You can request an interpreter at no cost to speak with Claremont Behavioral Services EAP Plan or a counselor. To request an interpreter or ask about written information in your language, first call Claremont EAP at 1-800-834-3773.

Usted puede solicitar un interprete a no costo para hablar con Claremont Behavioral Services EAP o con un consejero. Para pedir un interprete o preguntar acerca de informacion escrita en su idioma, primero debe llamar a Claremont EAP al numero de telefono 1-800-834-3773.

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

Your employer has chosen Claremont Behavioral Services to provide Employee Assistance Program (EAP) services ("Claremont EAP"). All EAP services covered under this Plan will be provided by Claremont EAP Providers.

Claremont EAP is a private firm specializing in employee assistance programs. Claremont EAP is **not** an insurance company.

This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

Any questions? Call our Contact Center at 1-800-834-3773

Table of Contents

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Welcome to Claremont Employee Assistance Program

Your employer has chosen Claremont EAP to provide Employee Assistance Program ("EAP") services for you and your eligible dependents. Claremont Behavioral Services, Inc. (the "Plan") is a specialized health care service plan licensed in California under the Knox-Keene Act to provide EAP services ("Claremont EAP"). 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.

Claremont Behavioral Services, Inc. Employee Assistance Program

1050 Marina Village Pkwy., Suite 203

Alameda, CA 94501

(800) 834-3773

Website: www.claremonteap.com

INTRODUCTION TO CLAREMONT EMPLOYEE ASSISTANCE PROGRAM

Claremont EAP is a Specialized California Health Care Service Plan providing an Employee Assistance Program headquartered in Alameda, CA.

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 Claremont EAP, call our Contact Center at the telephone number provided below. A representative in our Contact Center 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.

Organ Donation

California law requires Claremont EAP to notify you that each year, organ transplants save thousands of lives. Success rates are rising but there are far more potential recipients than donors. More donations are urgently needed. Organ and tissue donations may be used for transplants and medical research. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent. Please discuss a decision to become a donor with your family and physician. You may register as a donor by obtaining a donor card from the Department of Motor Vehicles. In California, you may also register online at: www.donatelifecalifornia.org.

Language Assistance

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services are available 24 hours a day, seven days a week, at no cost to you. For more information on the interpreter services we offer, please call our Contact Center.

Claremont Behavioral Services, Inc. Employee Assistance Program
1050 Marina Village Pkwy. Suite 203
Alameda, CA 94501
Telephone: (800) 834-3773

IMPORTANT TERMS

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

BENEFITS mean those Covered Services a Member is entitled to receive under the applicable Claremont EAP Specialized Health Care Service Plan Contract.

BENEFIT YEAR means each twelve (12) month prior beginning on the Effective Date until the termination of the Specialized Health Care Service Plan Contract.

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

COMBINED EVIDENCE OF COVERAGE/DISCLOSURE FORM (EOC/DF) means this document issued to a Subscriber/Member setting forth the coverage to which the Subscriber or Member is entitled.

COMMUNITY RESOURCES are defined as publicly available behavioral health and/or chemical dependency treatment or counseling resources. Community Resources are not included under this specialized health care plan. Claremont may refer Members to Community Resources as a supplemental benefit, but any fees for such Community Resources are not included under this specialized health plan.

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

COVERED SERVICES mean those services a member 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 counseling or referrals to medical psychiatric services.

EFFECTIVE DATE means the actual calendar date when the Specialized Health Care Service Plan Contract becomes effective. The 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, or serious bodily or psychological harm to you or others.

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.

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

EXCLUSIONS mean services that are not covered under the Plan.

FRAUD includes the deliberate submission of false information by a Provider, Subscriber, Plan Member, Plan employee or other individual or entity, to gain an undeserved payment on a claim or false information relating to the number of Members 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 Member and demands for confidential Member 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, and request for reconsideration or appeal made by a Member or the Member's representative. Where the Plan is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

INCIDENT means a newly emergent issue or occurrence and the related causes and consequences of such issue or occurrence that disrupt the relevant Member's personal functioning, health, state of mind, and/or quality of life. Examples include, but are not limited to, marital, family or personal relationship problems, emotional concerns, and substance abuse. A single Incident may manifest itself in multiple ways or over an extended period of time. For example, clinical depression is a single Incident that might affect or arise from several facets of a Member's life, such as his or her personal, marital, and work relationships. Claremont EAP shall make the final determination of what constitutes an Incident.

MEMBER means (1) the covered employee of a Subscriber organization ("Employee Member"); (2) an Employee Member's (a) lawful spouse or domestic partner, (b) dependent child (whether natural, adopted, step, foster, or the child of a spouse or domestic partner—collectively "dependent child(ren)"), up to and including children twenty-six (26) years old and regardless of whether the dependent child resides in the Employee Member's household, but provided the dependent child resides within the approved Service Area, and (c) family member (including but not limited to: child (dependent or otherwise), spouse, domestic partner, parent, or parent-in-law) resident in the Employee Member's household. Those in category (2) above are collectively "Dependent Member(s)." (See "Eligibility" section, below.)

PLAN means Claremont Employee Assistance (EAP) Plan.

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

PROVIDER includes a clinical psychologist (Ph.D.), licensed clinical social worker (LCSW), marriage family and child therapist (LMFT) or Licensed Professional Clinical Counselor (LPCC) who provides Covered

Services, including EAP assessment, referral and short-term counseling services, to Members under the Plan and who has agreed to accept negotiated rates as payment in full for services provided to Members.

SERVICE AREA means the geographic area within which the Plan will provide services. The Service Area is designated by zip codes listed within this Evidence of Coverage.

SESSION means an outpatient visit with a Provider conducted on an individual/family 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 Members, 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 Members.

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.

SUBSCRIBER CONTRACT means the contract between the Subscriber and Claremont EAP for the provision of EAP Benefits to eligible employees and dependents of employees.

OBTAINING YOUR EAP BENEFITS

Please read the remainder of this Combined Evidence of Coverage and Disclosure Form to fully understand how to use your Claremont Employee Assistance Program Benefits. Here's how to get started:

1. For confidential assistance, call our toll-free EAP number 24 hours a day: 800-834-3773.
2. An Intake Counselor will take your contact information and name of the covered employee's employer, 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.
3. All EAP services must be authorized prior to receiving services. Our Intake Counselors will assist you in completing the prior authorization process. It is important that you provide the Intake Counselor on the telephone with some detail regarding your concerns and preferences so that the Intake Counselor can refer you to a provider with the experience to best meets your needs.
4. The maximum number of visits provided under the Subscriber Contract are authorized by the Intake Counselor at the time of the telephone call. Once services have been authorized, Claremont EAP will provide you with the name(s) of a practitioner(s) appropriate for your issue, and you can contact the practitioner directly to schedule an appointment at a time that is convenient for you. If you do not reach the practitioner right away and have not received a call back within one business day, please call our Contact Center for assistance.
5. Claremont will notify the practitioner first so your call will be expected. There are no paperwork, claim forms or fees. This is an easy, no-cost service to help address a range of personal and professional issues.
6. Counseling sessions are conducted in person by the referred provider, unless other arrangements are made to the satisfaction of the Member.

PRINCIPAL EAP BENEFITS AND COVERAGE

This section summarizes the Covered Services provided to Members.

The Plan provides clinical assessment, counseling and referral for a variety of Incidents including, but not limited to:

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

The services offered by the Claremont EAP include problem assessment and counseling. Formal medical diagnoses or ongoing treatment services are not provided. EAP services provided to you may include referring you to non-covered community resources or, if applicable, your full-service health plan for ongoing assistance. You are responsible for the payment of any cost or fees for such non-covered services.

LIMITATIONS AND EXCLUSIONS

The Covered Services you are entitled to are limited to a maximum of 5 Sessions per Incident, per Benefit Year. Covered Services are also limited as follows:

1. Providers do not render services that are outside of the scope of their training, abilities, or experience.
2. Services provided by non-contracted providers are not covered, unless prior written authorization has been provided by the Plan.

Some services are not covered. Claremont EAP can help you determine if exclusions apply to you. The following services are specifically excluded:

1. Any service that has not been pre-authorized by Claremont EAP.
2. Services not listed under the section entitled “Principal EAP Benefits and Coverage” are not covered.
3. Child custody determinations.
4. Legal action taken against Member’s employer or any consultation related to employment law.
5. Aversion Therapy.
6. Biofeedback and hypnotherapy.

7. Court-ordered services, including services required as a condition of parole or probation, except to the extent the Member is otherwise entitled to services.
8. Services for remedial education, including evaluation or treatment of learning disabilities or minimal brain dysfunction; developmental and learning disorders; behavioral training; or cognitive rehabilitation.
9. Treatment or diagnostic testing related to learning disabilities, developmental delays, or educational testing or training.
10. Services received from a non-contracting Provider, unless prior written authorization is provided by the Plan.
11. Psychological testing.
12. 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.
13. Services of a psychiatrist (M.D.), including medication management or medication consultation.
14. Prescription drugs.
15. Inpatient, Outpatient, or Residential services for behavioral health or substance abuse treatment.

SECOND OPINION

If a Member has questions about an EAP provider's assessment of their problem or the action plan developed with such provider, or if the EAP provider is unable to make an assessment, the Member may contact Claremont EAP to discuss the assessment or action plan. The Member may also contact Claremont to discuss any concerns or questions they have if their problem is not improving within an appropriate time period. The Member may contact Claremont's Intake Counselors to request a second opinion. In such cases, the Member will be referred to an appropriately qualified professional – a licensed behavioral health care provider acting within the scope of his or her practice, who has a clinical background, including training and expertise, in connection with the condition or conditions for which the Member requested a second opinion. In such circumstances, there is no cost to the Member for a second opinion.

In a case involving an imminent, serious health threat, the Member's request will be processed on an expedited basis. A second opinion will be authorized or denied within 72 hours after Claremont's receipt of the request. For additional information regarding the availability of a second opinion, the Member can call Claremont EAP's Contact Center at 800-834-3773.

If a request for a second opinion is denied, the Plan will notify the requesting Member in writing of such decision with the reasons for the denial. A Member has the right to file a Grievance with the Plan for a denial of a request for second opinion. Please see the section on "Complaint, Grievance, and Appeals Procedures" for information regarding submission of a Grievance to the Plan.

CHOICE OF PROVIDERS

Listed services are provided through Providers who have agreed to enter into a written contract with Claremont EAP.

- All contracting Providers are appropriately licensed 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.
- EAP Providers may be licensed as Marriage Family and Child Therapists (LMFT), Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselor (LPCC) and Clinical Psychologists (Ph.D.). All perform EAP counseling within the defined scope of EAP services.

If the Plan is unable to offer the Member access to a contracted Provider within reasonable accessibility and time limits, the Plan may authorize Covered Services with a non-contracted provider. The Member must obtain prior authorization. Additionally, if there is a provider that is not currently contracted with Claremont EAP, a Member may also submit a prior authorization request to see that provider. If prior authorization is obtained, Claremont EAP will arrange for payment to the non-contracted provider – you do not need to make any payment to the non-contracted provider. If prior authorization is not obtained, you may be responsible for payment to the non-contracted provider.

Some contracting Providers are capable of conducting counseling services remotely via video. Video counseling sessions are accounted in the same way and subject to the same eligibility, limitations, and exclusions as non-video counseling. If you wish to conduct your counseling sessions via video, please tell your intake counselor so you can be referred to the appropriate Provider and provided instructions on accessing secure video services.

You do not need to make payment to a provider for any Covered Services that have been pre-authorized by Claremont EAP. Notify us if your provider attempts to collect payment for pre-authorized Covered Services or if you make any such payment to a provider by calling our Contact Center.

Please ensure that you make every effort to attend all appointments on time. In the event any Member does not show up for a scheduled appointment and has not provided at least 24 hour notice prior to the appointment, one visit will be deducted from the number of visits Member is entitled to for that Benefit Year. A visit will not be deducted from the number of visits the Member is entitled to if the Member is unable to give 24 hours' notice due to circumstances beyond the Member's control.

FACILITIES

You may obtain information regarding the identity and location of Provider facilities by contacting Claremont EAP by telephone at (800) 834-3773.

CONTINUITY OF CARE

1. Terminated Providers – Should the Provider, or the Plan terminate a provider contract, Members may request continuity of care for assessment and referral, or counseling services that began prior

to the date of termination. The Plan will authorize and cover the completion of remaining services. The Plan will provide you written notice prior to the termination of any contracting EAP Provider. The notice will include information on how to request continuity of care.

2. New Employee – any new Member 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, may request continuity of care to continue counseling with that Provider under the former plan. Such new Member will be allowed a reasonable transition period to continue his or her course of treatment with the prior EAP service Provider. The Plan will authorize and cover the completion of the remaining services, up to the limits of the number of counseling Sessions to be provided by the Plan under the new Subscriber Contract. The Plan will not attempt to offer or cover continuity of care beyond the scope of employee assistance services and its licensed capabilities.

OBTAINING EMERGENCY SERVICES

In the event that a Member is having or believes that he/she is having a medical or psychological emergency, the Member 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.

Members 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 provide appropriate intervention.

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

INDEPENDENT MEDICAL REVIEW

A member may request an independent medical review in accordance with the Independent Medical Review System established under Article 5.5 of the Health and Safety Code (section 1374.30 et seq.).

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 Claremont EAP.

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 Claremont Employee Assistance Program to your employer for determination.

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

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

1. The lawful spouse or domestic partner of the Employee Member.
2. An Employee Member's dependent child, up to and including age twenty-six (26), irrespective of the dependent child's place of residence, marital, financial, or student status, providing, however, that the dependent child resides within the approved Service Area. Dependent adopted children, stepchildren, and foster children are covered from and after the date of placement and are included in all references to an Employee Member's "child(ren)" or "dependent child(ren)."
3. Coverage will not terminate while a 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 Employee Member for support and maintenance, provided the Member furnishes proof of such incapacity and dependency to Claremont Employee Assistance Program within sixty (60) 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, Employee Members' family members (including but not limited to a child (dependent or otherwise), spouse, domestic partner, parent and parent-in-law), if residing in the Employee Member's household, are eligible for Covered Services under the Plan. Dependents are eligible for coverage on the date the Employee Member becomes eligible for coverage, or as of the date a covered Employee Member acquires such dependent.

Dependent Members, as described above, who do not reside within the Plan's approved service area are not automatically enrolled in the Plan, and the Plan is not required to provide Covered Services to Dependents who do not reside within the approved Service Area. Out-of-area Dependents seeking Covered Services may request authorization from the Plan prior to obtaining such services. Any Covered Services rendered to out-of-area Dependents which have not been pre-authorized by the Plan will not be paid for by the Plan.

ENROLLMENT

All eligible Members who live or work within the Plan's Service Area are automatically enrolled with Claremont EAP and qualified to receive Covered Services.

EFFECTIVE DATE OF COVERAGE

The beginning of eligibility coverage is determined by the Specialized Health Care Service Plan Contract Effective Date. Subscriber employees whose employment with a Subscriber begins after the effective date of the Specialized Health Care Service Plan Contract are covered as Members as determined by the contract and the Member's Subscriber employer benefit policy.

RENEWAL PROVISIONS

Your employer (the Subscriber) and the Plan will decide the continued coverage and renewal of Benefits pursuant to the terms of the Subscriber Agreement. The Plan reserves the right to modify the provisions of this contract, including provisions relating to premiums. Any notification of termination, nonrenewal, or change in Benefits will be communicated to you by the Subscriber.

SUPPLEMENTAL BENEFITS

In addition to EAP benefits, enrollees of Claremont EAP also have access to other services. Claremont EAP will provide the services described below during normal business hours at designated office locations at the request of enrollees and upon prior authorization by Claremont EAP.

Service	Description	Amount
Legal Consultations	Provide Members with one initial telephonic or in-person 30-minute legal consultation, per issue, with a qualified legal professional. A 25% discount is available for any legal services beyond the initial consultation. Attorneys have expertise in areas such as family law, consumer issues, traffic violations and personal injury, etc. A "Simple Will" kit is available to each Covered Individual upon request.	Consultations: One (1) per issue. Will Kits: One (1) per Covered Individual.
Financial Consultations	Provide Members with one 30-minute telephonic or in-person consultation, per issue, with a financial specialist to such Covered Individuals with budgeting, retirement planning, credit report reviews, debt consolidation, financial planning, stock option plans, auto and real estate purchasing issues.	Consultations: One (1) per issue.

Child Care Consultations and Referrals	Provide Members with one telephonic consultation per issue to assist with child care and parenting issues; provide referrals to family day care homes, infant centers, pre-schools, before/after school programs, sick/emergency care, in-home options, and care for special needs children.	Unlimited Consultations and Referrals.
Elder/Disabled Care Consultations and Referrals	Provide Members with one telephonic consultation per issue to assist with elder care and disabled adult issues; provide referrals to elder/disabled care providers and/or support services for those issues.	Unlimited Consultations and Referrals.
Pet Care Referrals	Provide Members with one telephonic consultation per issue; provide referrals to vets, animal hospitals, pet services, groomers/boarders, transportation services, pet insurance, and obedience classes for their pets; provide educational materials including tip sheets and checklists also provided.	Unlimited Consultations and Referrals.
Adoption Assistance	Provide Members with telephonic consultations about adoption options and the adoption process; provide referrals to public and private adoption agencies, adoption support organizations, single parent adoptions, adopting special needs children, step-parent adoptions, and international adoptions; provide educational materials including tip sheets and resource listings.	Unlimited Consultations and Referrals.
School and College Selection Assistance	Provide Members with telephonic consultations about school and college selection issues; provide referrals to elementary and secondary public/private schools and after school programs, state/private colleges and universities, test preparation courses, financial aid, educational consultants; provide educational materials including College Guidebook, SAT information, tip sheets, checklists, and resource listings.	Unlimited Consultations and Referrals.
Community Resources Referrals	Provide referrals for Members to available Community Resources for assistance with personal- or work-related issues affecting the quality of life of the	Unlimited Consultations and Referrals.

	Member requesting the referral (e.g., substance abuse programs, domestic violence support groups).	
Convenience Referrals	Provide referrals for Members to available daily living services such as home repair, errand services, travel, entertainment and apartment locator services.	Unlimited Consultations and Referrals.
Wellness Referrals	Provide help with physician searches, medical support groups, fitness centers, diet & nutrition resources, alternative medicine and other resources	Unlimited Consultations and Referrals.

CONFIDENTIALITY AND RELEASE OF INFORMATION

The Plan will maintain the confidentiality of all Member EAP records except to the extent that disclosure is authorized by the Member in writing, or is otherwise mandated or allowed by federal and state law. Please see Claremont's Notice of Privacy Practices for a complete list of permitted disclosures. 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 Member case records are to be maintained.

Confidential information is maintained in accordance with the Federal Health Insurance Portability & Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH").

A STATEMENT DESCRIBING CLAREMONT'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. You may request a paper copy of this Notice at any time by contacting the Plan at 800-834-3773. The Plan's Notice of Privacy Practices is also available on the Plan's Member website at www.claremonteap.com.

ANTI-DISCRIMINATION NOTICE

The Plan will not cancel, decline to renew, or decline to reinstate any Subscriber Contract, or refuse to enroll, accept, or renew any person as a Member, 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, Member, dependent, 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, Subscriber organizations and their Members, in the delivery of employee assistance services through the timely detection, investigation, and prosecution of suspected Fraudulent activities.

Subscribers and their Members should file a report of suspected or alleged fraudulent activities to Claremont EAP. The filing of any report will be treated confidentially and should be filed with the Plan's Vice President of Operations, who can be contacted by mail at 1050 Marina Village Parkway, Suite 203, Alameda, CA 94501 or by telephone at 800-834-3773.

Any report of suspected or alleged fraudulent activities will be immediately investigated with strict confidentiality.

TERMINATION OF BENEFITS

In most cases, your coverage will end when the contract between your employer (Subscriber) and Claremont EAP is terminated. 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 a Member (employee or dependent), or the Plan no longer wants to provide services to you because of your conduct as described below.

Your coverage cannot be cancelled or not renewed 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 Contact Center as described in the "Complaint, Grievance, and Appeals Procedure" section of this Evidence of Coverage/Disclosure Form, or online at www.claremonteap.com, or by calling 800-834-3773. You may also request a review by the Director of the California Department of Managed Health Care.

1. ***Termination by your employer (Subscriber) –*** Subscriber shall have the option to terminate this contract for cause upon thirty (30) days written notice to the Plan.

2. ***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 non-payment. The Plan will first give your employer thirty (30) days notice of our intent to terminate the Subscriber Contract for non-payment. 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. Ongoing treatment will not be interrupted due to non-payment or contract termination.

3. ***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" includes 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 thirty (30) days after receipt of notice of cancellation.

If a Member believes the contract for EAP services has been or will be improperly cancelled or not renewed, the Member may request a review by the Plan or the Director of the Department of Managed Health Care pursuant to Section 1368 of the California Health and Safety Code.

The Plan does not engage in retroactive termination, and as a Member (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 elect to continue your EAP benefit through your employer under COBRA to continue receiving Benefits and Covered Services pursuant to the Subscriber Contract and this Combined Evidence of Coverage and Disclosure Form.

You must notify your employer that you elect to continue the EAP benefit. Your employer will include your name on a list of employees who have selected the EAP benefit under COBRA, and will provide the Plan this updated list on a regular basis. If you elect to continue this benefit, you will be responsible for the premium payment. Your employer will provide you information on the monthly premium due for your continued coverage and the process for remitting payment through the employer. You will not be responsible for filing a claim for EAP services under COBRA.

LIABILITY OF SUBSCRIBER OR MEMBER FOR PAYMENT

CO-PAYMENT

There are no Co-Payments due or payable by Members. 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 have any responsibility for payment of any Premiums or Co-Payments for EAP services provided to you under the Plan.

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, Members are required to access all EAP services through the Plan's EAP nationwide toll-free number, 800-834-3773, available to Members 24 hours/day, 7

days/week. You do not need to make payment to a provider for Covered Services that have been pre-authorized by Claremont EAP.

OTHER CHARGES

For services approved by Claremont, there are no copayments, coinsurance, or deductible requirements. However, if you continue to seek services after exhausting the approved number of Provider visits, you may be responsible for charges for such services.

LIABILITY FOR SUMS OWED BY CLAREMONT 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. 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. In the event the Plan fails to pay a non-contracted provider, the Member may be liable to the non-contracted provider for the cost of services.

REIMBURSEMENT PROVISIONS

In the event you render payment to a Provider in exchange for provision of pre-authorized Covered Services, the Plan will reimburse you to the extent of such payment. If you believe you have improperly rendered payment for Covered Services, contact Claremont in accordance with the Grievance policy detailed below.

HOW CLAREMONT EAP COMPENSATES EAP PROVIDERS

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

Claremont EAP does not pay financial bonuses or other incentives to the Plan Providers. Should you wish to know more about these issues, please call our Contact Center at 800-834-3773.

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, you will be responsible for payment and the Plan will not pay for services.

COMPLAINT, GRIEVANCE, AND APPEALS PROCEDURES

COMPLAINT/GRIEVANCE PROCESS

Claremont Employee Assistance Program has established a Grievance process for receiving and resolving Member complaints. If you experience any problem with services delivered through Claremont EAP, call the Contact Center at 800-834-3773. You may also submit a complaint or grievance online at www.claremonteap.com, or by mailing notice of your grievance to:

Claremont Behavioral Services, Inc. Employee Assistance Program
Contact Center
1050 Marina Village Parkway, Suite 203
Alameda, CA 94501

The Clinical Director reviews any complaint involving care that has been received or denied.

A Grievance may be filed within 180 calendar days following any incident or action that is the subject of dissatisfaction.

The Plan will acknowledge in writing receipt of the Grievance within five (5) calendar days and will provide written resolution of the Grievance within thirty (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 the Grievance.

Claremont EAP is committed to customer satisfaction as a key indicator of quality. Members and Providers have the right to file complaints and grievances and to attain resolution to their concerns promptly and appropriately.

A complaint is the same as a Grievance. A Grievance means a written or oral expression of dissatisfaction regarding the Plan and/or Provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a Member or Member's representative.

You may file a complaint by phone, in writing, or online at www.claremonteap.com/contactus. Our toll-free number is 800-834-3773 or address your correspondence to:

Claremont Behavioral Services, Inc. Employee Assistance Program
Attention: Contact Center
1050 Marina Village Parkway, Suite 203
Alameda, CA 94501

Neither the Plan nor any of its participating Providers will discriminate against a Member based on the filing of a Grievance. If you believe that you have been discriminated against due to your filing a Grievance, please notify us by calling the Contact Center at 800-834-3773.

MEMBER PROCESS

Our Grievance policies and procedures have been developed to address Member complaints, quality of care and service issues, and appeals. Claremont EAP's grievance procedures will be communicated to all Members at the time of membership and annually thereafter, by way of Claremont EAP's Combined Evidence of Coverage and Disclosure Form. The Grievance process, a printable Grievance form, and instructions for submitting Grievances online are described and available on Claremont EAP's website at www.claremonteap.com/contactus, or by calling 800-834-3773, or by writing sent to the following address:

Claremont Behavioral Services, Inc. Employee Assistance Program
Contact Center
1050 Marina Village Parkway, Suite 203
Alameda, CA 94501

There are two categories of Member complaints. A non-clinical complaint expresses dissatisfactions that do not have a clinical component, including but not limited to interaction with staff or Provider, etc. Clinical complaints are directly related to the appropriateness of medical care, such as quality of care. All Grievances are acknowledged in writing within 5 calendar days of receipt and are handled in a manner to allow closure within 30 calendar days. Urgent Grievances involving an imminent and serious threat to the health of the patient, including but not limited to severe pain, potential loss of life, limb, or major bodily function, shall be handled on an expedited basis. In such cases, the Plan shall immediately notify the Member of the right to contact the Department regarding the grievance. The Plan will provide a written statement to the Member and the Department of Managed Health Care on the disposition or pending status of the urgent grievance within 3 calendar days of the receipt of the grievance by the Plan.

All borderline inquiries that may be complaints are treated as complaints. All quality of care Grievances are brought to the attention of the Clinical Director within 24 hours of receipt. A Grievance may be initiated by telephone, online, or in writing.

The Grievance system shall address the linguistic and cultural needs of its Member population. Assistance for those with limited English proficiency will be provided upon request.

The Clinical Director has responsibility for documenting Member concerns, for pursuing the resolution of issues, and for maintaining the tabulated records of the complaints. Data is aggregated monthly and reviewed by the Clinical Director and the Vice President of Operations.

After researching the issues, the Clinical Director communicates Claremont EAP's decisions to Members.

1. Claremont EAP provides Members with written responses including a clear and concise explanation of the reasons for Claremont EAP's decision.
2. In cases of delay, denial, or modification of services, the criteria used and the clinical reasons are presented to the Member

3. If Claremont issues a decision delaying, denying, or modifying health care services based on a finding that the proposed health care services are not a covered benefit under the contract that applies to the Member, the decision shall clearly specify the provisions in the contract that exclude that coverage.

With the assistance of Claremont EAP management, and in the case of quality of care issues, with the guidance of the Clinical Director, Member concerns will be resolved expeditiously. All levels of resolution or appeal will be completed within thirty (30) calendar days of the Plan's receipt of the Grievance.

ARBITRATION

All Grievances that are not resolved in the above manner shall be brought to binding arbitration. Arbitration is a way to solve disputes without filing a formal lawsuit or going to court. This is disclosed to Members and Providers in the Evidence of Coverage and Disclosure Form. These second level appeals of Claremont EAP decisions are brought to the immediate attention of the Board of Directors. Claremont EAP shall cooperate in the resolution of appeals within the commercial rules of Judicial Arbitration and Mediation Services, Inc. (JAMS), and the Member's fees will be waived in the case of financial hardship, as may be determined by the JAMS. Arbitration may be initiated by following the directions on JAMS website www.jamsadr.com.

All disputes arising under the Subscriber Contract that applies to the Member, including cases of alleged medical malpractice, will be resolved through neutral arbitration and neither the Subscriber nor Member will retain any right to a trial by jury or a court trial in the case.

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to the Subscriber Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care is responsible for regulating health care services plans. If you have a Grievance against your health plan, you should first telephone your health plan at **800-834-3773** 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 **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 Plan Members from the 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 Members, and contract Providers, to assure the comfort, dignity, and convenience of Members seeking EAP services for themselves, their families, and the public. Committee members shall have access to information from the Plan regarding public policy, including financial information and information about the specific nature and volume of complaints received by the Plan and their disposition.

In selection of Members, Claremont shall consider the makeup of its Member population, including but not limited to factors such as ethnic extraction, demography, occupation, and geography, as well as identifiable and individual group participation. Any such selection shall be conducted on a fair and reasonable basis. This does not require the Plan to maintain supporting statistical data.

If you are interested in becoming a member of the Public Policy Committee and would like more information, please call us at 800-834-3773.