Anthem

EMPLOYEE ASSISTANCE PROGRAM (EAP) PARTICIPANT ORIENTATION

Please read thoroughly before signing and direct any questions to your consultant.

DESCRIPTION OF SERVICES: Your Company has contracted for EAP services which provide professional consultation for employees and their family members regarding a wide range of personal problems. Available services may include: assessment, short-term counseling, and referral. If longer term counseling or specialized services are needed, the EAP will refer you to qualified professionals or organizations in the community. You EAP will then follow up to determine if your needs are being met. Certain insurance plans require an EAP referral in order to utilize your mental health and substance abuse EAP services.

FEES: There are no direct fees to employees or family members for any EAP covered service received. When the EAP refers to resources in the community for ongoing or specialized services, you are responsible for paying any applicable fees. Your group health plan may or may not cover some of the cost of referred services. If the EAP makes a referral that may utilize your company's insurance benefits, it is your responsibility to verify both your insurance eligibility and the benefits available for behavioral health. This can be done by contacting either the insurance company or your benefit department. It will also be your responsibility to ensure that any provider to whom the EAP may refer you is a participating network provider.

CONFIDENTIALITY: When an individual utilizes EAP services, the information will be held confidential unless: 1) the individual authorizes release of information with a signature; 2) the individual represents, in the EAP consultant's opinion, a physical danger to self or others; 3) child abuse/neglect, elder abuse/neglect, or dependent adult abuse/neglect is suspected; 4) a court order for records is issued; 5) where legally permitted or required by law to disclose the applicable data, and then only to the extent necessary.

If you are employed by a company contracted with or regulated by the Departments of Defense or Transportation or the Nuclear Regulatory Commission, the EAP may be required to disclose information about your EAP consultation under the following conditions: a) there is a significant breach of security or safety policies, b) the EAP receives an administrative summons or judicial subpoena or order, c) you were referred due to a positive drug test, d) as further defined by your employer. The EAP does not make routine "adverse information" reports.

VOLUNTARY PARTICIPATION: The decision to participate in the EAP is voluntary in most cases. Employees participating in the program should not expect any special privileges or exceptions to normal work rules or performance standards. EAP participation is not to be interpreted as constituting a waiver of management's rights to take disciplinary measures, nor shall the program be interpreted as a waiver of the right of any employee to use a complaint procedure within the framework of company policies.

EMPLOYER REFERRAL: When an employee is referred to the EAP by the employer, the appropriate company representative of the organization may be advised with the employee's consent if: 1) the employee kept the appointment; 2) the EAP consultant has made recommendations; 3) the employee has agreed to follow these recommendations.

GRIEVANCE PROCEDURE: If you are dissatisfied with the EAP service you receive, you may file a grievance in writing or by phone to the Grievance & Appeals Department, at the following address: Anthem Blue Cross, BH Grievance and Appeals, PO Box 4310, Woodland Hills, CA 91365, Fax: (877) 487-7394, or online at: www.anthemeap.com. **We are required to inform you of the following:**

Client Name: _____ Client Signature: _____ Date: _____
(Please Print)

Company Name: _____

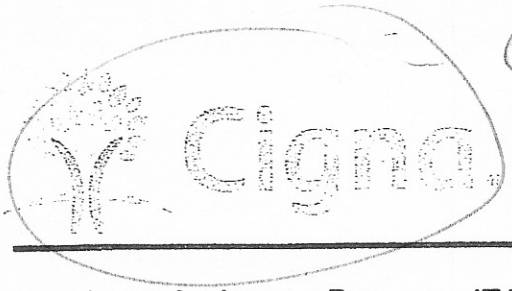
Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de su Programa de Asistencia para el Empleado

Anthem

EAP Freedom of Choice Information

Your employer-paid EAP counseling sessions have been completed. You and the provider have discussed the nature of your problem(s) and the Provider has recommended additional behavioral health services. The Provider and you should have reviewed all of the alternatives for continuing services including factors of geography, provider specialization, financial arrangements, and insurance coverage. Having carefully considered all of these options, it is important that you understand you are exercising free choice if you decide to continue treatment with your EAP provider. With your decision, the responsibility for payment will transfer to you and/or your health plan.

EAP is not responsible for payment of services beyond the number of sessions allowed under your EAP benefit.



Cigna

Employee Assistance Program (EAP)
STATEMENT OF UNDERSTANDING

Employee Assistance Programs (EAPs) are provided by many employers who wish to offer their employees and family members a professional assessment and referral service.

This information is provided to you to help you better utilize available EAP services.

FEES
Sessions within the EAP are offered at no cost to the employee or family members. Your employer has already paid for this service.

If an employee or family member needs specialized counseling or treatment services, he or she will be assisted in locating an appropriate resource. While medical benefits may defray some of the costs of the services provided by these resources, the employee or family member assumes financial responsibility for such services.

PRIVACY
Information concerning the use of the EAP will not be given to anyone outside the EAP without your permission unless required by law. Certain state laws require that the EAP staff assume the responsibility for reporting to appropriate parties instances when a person is a danger to him or herself, to others, or when child or vulnerable adult abuse/neglect is involved.

SELF REFERRALS
If an employee or family member initiates a request for assistance, no one will be notified of the individual's use of the EAP service without that individual's written permission.

SUPERVISOR REFERRAL
If a supervisor initiates the referral of an employee as the result of a performance discussion, or as a result of a positive drug screen, the supervisor will be notified whether or not the employee has kept the appointment with the EAP professional.

VOLUNTARY PARTICIPATION
Use of the EAP is voluntary. It is the client's decision whether to use (or not to use) the services available. In some cases, as noted above, your employer may require participation in the EAP as a condition of employment or as a part of the company's substance abuse policy.

COMPLAINTS AND GRIEVANCES
If you have a complaint concerning a person associated with CIGNA Behavioral Health's EAP, an EAP service, the quality of services, or any other aspect of the EAP, you may register the complaint with our Customer Service Department by calling 1-800-926-2273.

I have read and received a copy (if requested) of this information.

Signature _____ Date _____

FORM #00033 REV. 12/2012

Beacon Health Options

EAP Affiliates and Staff: Please offer to read the following statement to EAP participants and discuss the content with them, providing any additional assistance required to review and understand this document particularly for individuals with special needs.

EMPLOYEE ASSISTANCE PROGRAM
EAP PARTICIPANT STATEMENT OF UNDERSTANDING

To Our EAP Participants:

Beacon Health Options, Inc. is pleased that you have decided to use your Employee Assistance Program ("EAP"). The EAP is a voluntary service available to eligible employees and family members. There are several things we want you to know before we begin discussing your reason for contacting the EAP.

Personal problems are sometimes very difficult to talk about. That is why confidentiality is extremely important to us. We take every precaution in protecting the confidentiality of your visit with us and we hope that you will do the same. A written and electronic record (date, time, nature of meeting) of your contacts with the EAP will be maintained in a secure manner. Access to the record will not be given to anyone outside of the EAP, except as required by law or as described below. To access your file, contact Beacon Health Options, Inc.

This provides an opportunity for you to discuss personal problems with us. We will help you with an assessment of your personal problems and then develop a plan of action with you. The plan of action may include a referral to an appropriate resource to help you resolve your problems. After the referral is made, we will follow up to be sure the referral is satisfactory. In the event that there is no referral, we will still develop an action plan with you.

Lawful release of records is permitted under the following conditions: if we learn about child, elder or disabled adult abuse or neglect, if you pose a threat of imminent danger to yourself or others, if we are required to present records to comply with a court order, to comply with other state and federal requirements, and if we learn about any emergency medical circumstances which require immediate medical attention.

To the extent possible, we want to ensure the counselor that you will be meeting with is a person with whom you are comfortable. For example, some people have a preference for a counselor of a particular gender, sexual orientation, ethnicity, or religion. If this is a concern, Beacon Health Options, Inc. would like to give you the opportunity to let us know so that we may attempt to arrange a referral to a counselor that is appropriate for you. Should you have any concerns or be dissatisfied with the EAP or your counselor, please contact Beacon Health Options, Inc.

There is no cost to you for any EAP services provided by Beacon Health Options, Inc. The Employee Assistance Program does not, however, cover the costs of therapy or community resources/treatment services to which you may be referred. We attempt to maintain up-to-date information on your health insurance coverage so that we can refer you to providers covered by your plan. However, it is your responsibility to verify that your insurance will cover the cost of such therapy or other treatment or resources.

I hereby acknowledge that I have read and understand this Statement of Understanding.

Participant Name (Please Print)	Participant Signature	Date
Participant Name (Please Print)	Participant Signature	Date

If you are signing this form on behalf of someone other than yourself, please enclose with this form proof of your authority to do so and attach written documentation (i.e. Guardianship Order, Custody Order, Court Order) as appropriate.

Carebridge

STATEMENT OF UNDERSTANDING

Instructions: At the first appointment, have client or guardian read and sign the Statement of Understanding. Please offer a copy of the Statement of Understanding to the client.
Please submit billing electronically or fax or mail billing to Carebridge EAP.

Extent of EAP Services:

The EAP offers assessment, consultation, and short-term counseling for your personal concerns. Often short-term counseling is completed within the allotted EAP sessions. However, the number of recommended sessions is determined by your counselor. If the EAP counselor determines that long-term counseling or a higher level of care is recommended, your unused EAP sessions will be "banked" for future visits within the next 12 months if needed. You will have to call Carebridge to reauthorize these sessions. If you violate the counselor's missed session or late cancellation policy, you may forfeit one of your EAP sessions.

Completion of Leave or Legal paperwork:

I understand that it is out of the scope of the EAP to provide documentation or testimony for court or legal issues, court-ordered counseling or treatment, evaluation or documentation for FMLA, disability, or other work-related leave of absences. If these services are needed, please consult with a care manager at Carebridge.

Cost:

There are no charges to you or your covered family members for using the EAP services. There may be charges, however, should you be referred to, and choose to utilize, the services of other professionals. If an outside referral is chosen, every effort will be made to find the best resource at the lowest cost to you. Certain costs may be partially offset by your Medical Benefit Plan. *I understand that it is my responsibility to verify my medical benefit coverage and benefits for continued sessions with this Affiliate.*

Confidentiality:

All records kept by the EAP will be treated confidentially. No information can be released outside the EAP without your written consent, unless required by law. Various laws require that the EAP staff assume the responsibility for reporting to appropriate parties instances when a person is a danger to themselves, to others, or when elder/child abuse/neglect is involved. To keep this program confidential, your employer has contracted with Carebridge, an independent outside benefit firm, to administer the EAP.

Formal Referrals:

If a supervisor requires that you contact the EAP (for instance, because of a performance concern), the supervisor will not be informed of any details of your counseling without your signed consent.

Complaints:

If you have a complaint concerning any person associated with the EAP service, the quality of service provided, or any other aspect of the EAP, you may register the complaint with Carebridge by calling *800-437-0911.*

Satisfaction Survey:

As a part of quality assurance, I further authorize Carebridge to contact me to survey my satisfaction with the services I receive.

Signature:

I have read this statement and may request a copy for my records.

CLIENT INFORMATION

Client Name: _____ EAP Case Number: _____

By signing this statement of understanding, I agree to allow the Affiliate to invoice Carebridge EAP for my counseling sessions, as well as provider case notes, consultation and case collaboration to Carebridge.

Client/guardian signature: _____ Date: _____

EAP Affiliate signature: _____ Date: _____

Mutual of Omaha

Authorization Of Service

Authorization ID: [redacted]

RETURN TO: Mutual of Omaha EAP
H01W-151
Mutual of Omaha Plaza
Omaha NE 68175
Fax# 402-351-6308

STATEMENT OF UNDERSTANDING AND CONSENT

The Mutual of Omaha Employee Assistance Program is a confidential assessment and referral resource provided for employees and their dependent family members. Included in the service is the opportunity for one or more face-to-face visits.In the event the assessment results in a recommendation for referral to a specialized provider or to a community resource, the Mutual of Omaha EAP professional can assist you in that process. Additional costs for services beyond those authorized by the EAP are the responsibility and obligation of the employee client and may or may not be covered by your health benefits plan. You may decline or discontinue these services and/or recommendations at any time.
CONFIDENTIALITY. All information that is obtained, discussed, and/or recorded during the EAP session will be maintained in confidential files. This information will remain confidential except for the following circumstances:

1. When you request and provide written permission/consent for the release of specific disclosure;
2. The life or safety of yourself or others is seriously threatened;
3. Child abuse: The law requires that child abuse be reported;
4. EAP records are the subject of a court order (subpoena);
5. Other disclosures required by applicable law.

ACKNOWLEDGEMENT/UNDERSTANDING. I have read and understand the above information relating to the confidentiality of the information discussed in the assessment. I also understand that I am not required to abide by the recommendations made following the assessment, that if I chose to follow those recommendations, this decision is to be made by me of my own free will.

Signature of Client (Guardian/if minor) _____ Date: _____

AUTHORIZATION OF RELEASE OF INFORMATION TO THE EAP OF MUTUAL OF OMAHA

I, (Client Name)_____authorize (Provider Name)_____

the following affiliate provider, to disclose personal information about me to Mutual of Omaha Employee Assistance Program, a service of Mutual of Omaha Insurance Company. The personal information that may be disclosed includes session dates, assessment and case summary, recommendations for care, and referral information. The purpose of the disclosure is for case management and the coordination or continuity of services. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain payment or my eligibility for benefits. Unless revoked earlier, this authorization will remain in effect for 12 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to the EAP of Mutual of Omaha. I realize that my right to revoke this authorization is limited to the extent that Mutual of Omaha Employee Assistance Program has taken action in reliance on the authorization and won't have any affect on any action they took before they received the revocation.
I understand that I am entitled to receive a copy of this signed authorization. I also understand that a copy of this authorization is as valid as the original.

(Signature)_____ (Date)_____

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

New Avenues
Midwest Behavioral Health Network

New Avenues, Inc. Employee Assistance Program
Statement of Understanding

Employee Assistance Program · P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925-5730 · Fax: (574) 271 – 5980

Purpose of Statement of Understanding

The purpose of this Statement of Understanding is to explain how the Employee Assistance Program (EAP) works and to outline for you what can be expected from the program. This information is to help you better understand and use your EAP.

The Employee Assistance Program is a short term solution-oriented counseling program. It is based on your employer's desire to offer their employees and family members help in managing problems that may affect personal well being, work performance and/or family life.

Your Responsibility

Your employer has paid for this program, it is important for you to respect this benefit and respect your Provider (Counselor) by attending the scheduled sessions. If you find a need to cancel an appointment, please call your Provider 24 hours ahead of time. The provider has the right to exercise an option not to reschedule if one or more failed appointments have occurred without appropriate or reasonable notification.

Fees

Brief counseling in the EAP is offered at no cost to the employee and immediate family members living in the employee's household, or children living with a custodial parent if the employee has consented for a dependant to use this service. Your employer has already paid for this service. If you or a family member needs specialized or additional help beyond the scope of the EAP, discuss this with your Provider. Services not covered by the EAP include psychological testing, psychiatry visits, intensive outpatient programs, extended counseling, classes, court reports, or inpatient treatment. While your insurance may defray some or all of the cost of the services provided outside of the EAP, you, the employee (or family member) are responsible for payment of these services. The employee or family member is also responsible for knowing if the insurance plan is in effect at the time of service and whether pre-authorization is required. Your Provider can help in attaining a referral from your insurance plan if pre-certification is required for services not included in the EAP.

Privacy

New Avenues EAP will not give information about your using the EAP to anyone outside the EAP without your permission, unless we are required to by law. Your participation in the EAP is confidential, your employer will not receive your name or any information that would identify you unless you give us your written permission to do so or you chose to tell your employer yourself.

Your Provider is required by law to give you their own Notice of Privacy Practices.

Supervisory Referral

If a supervisor refers you to the EAP after discussing your work performance, or as a result of a violation of a work policy, you will need to sign an Authorization Form for Consent to Release Information before we will give any information to your employer.

Voluntary Participation

Using the EAP is voluntary and in most situations is based on your decision to seek counseling. It is the client's decision to use (or not to use) the services. In some cases, as noted above, your employer may ask you to participate in the EAP because of your work performance or related disciplinary action for violation of a work policy.

Complaints or Compliments

If you wish to make a comment or complaint about any part of your EAP experience, the quality of services, or any other aspect of the EAP, you may call directly to the New Avenues EAP administrative offices at 574-232-2131 or 800-731-6501 or you may wish to speak to your company's Human Resource Department. If you have given us permission at the time of your initial call to New Avenues we will be sending a Client Satisfaction Survey to your home. This is another opportunity for you to give us your feedback about the services you received.

Please sign below indicating you have read, understand this statement and agree to the terms of the EAP. Your Provider can answer any questions concerning the statement you might have.

_____ _____

Client Signature Date

PLEASE GIVE THE CLIENT A COPY OF THIS FORM and RETAIN A COPY IN THE CLIENT FILE