CITY OF CHULA VISTA

EXHIBIT C

EMPLOYEE ASSISTANCE PROGRAM

AETNA RESOURCES FOR LIVING
(dba Horizon Health EAP – Behavioral Services)

PLAN DOCUMENT

Amended and Restated as of January 1, 2017

Human Resources Department
City of Chula Vista

HEALTH AND HUMAN RESOURCE CENTER, INC.
(dba AETNA RESOURCES FOR LIVING)

EMPLOYEE ASSISTANCE PROGRAM (EAP)

SERVICES AGREEMENT

Cover Sheet

Initial Term of Agreement: ..... January 1, 2015 through December 31, 2017

Date of Submission of Initial Periodic Fees: ..... January 1, 2015

Effective Date of Coverage for Initial Members: ..... January 1, 2015

Initial Periodic Fee: ..... $1.79 Per Employee Per Month

Other Pertinent Information:

Exhibits: A and B

Group
City of Chula Vista

By: Kelley K Bacon
Its: Deputy City Manager
Date: 11-4-14

276 Fourth Avenue
Chula Vista, CA 91910
Telephone: (619) 691-5284

Plan
Health and Human Resource Center, Inc.,
dba Aetna Resources For Living

By: (Peggy Wagner)
Its: President
Date: 11/20/14

10260 Meanley Drive
San Diego, CA 92131
Telephone: (800) 890-1921

RETURN THIS SIGNED ORIGINAL TO PLAN

HEALTH AND HUMAN RESOURCE CENTER, INC.
(dba AETNA RESOURCES FOR LIVING)
EMPLOYEE ASSISTANCE PROGRAM (EAP)
SERVICES AGREEMENT

This Employee Assistance Program (EAP) Services Agreement ("Agreement") is made and entered into by and between Health and Human Resource Center, Inc., doing business as Aetna Resources For Living ("Plan"), and the organization identified as Group on the Cover Sheet of this Agreement ("Group").

RECITALS

A. Plan operates a specialized health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975, as amended (the "Act"), and the regulations promulgated thereunder (the "Regulations").

B. Plan will provide and arrange for the provision of Benefits to Group employees and certain persons associated with Group employees, as Members, in accordance with the terms, conditions, Limitations and Exclusions of this Agreement, as such terms are defined below.

C. Group will pay Periodic Fees to Plan for the provision of Benefits by Plan to Group employees and certain persons associated with Group employees, as Members.

AGREEMENT

NOW, THEREFORE, in consideration of the above recitals and the promises and covenants contained herein, Plan and Group agree as follows:

I. DEFINITIONS

The following terms shall have the following meanings:

A. "Act" The Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code Sections 1340 et seq.).

B. "Benefits" The coverages to which Members are entitled under this Agreement, and the services to be provided to Group hereunder, which are set forth in Exhibit A to this Agreement.

C. "Director" Director of the California Department of Managed Health Care.

D. "EAP Provider" A licensed assessment and short-term counseling professional employed by, or under contract with Plan to provide Benefits to Members.

E. "Exclusion" Any provision of this Agreement whereby coverage for Benefits is entirely eliminated.

F. "Evidence of Coverage" or "Combined Evidence of Coverage and Disclosure Form" The document issued to an employee of Group which summarizes the essential terms of this Agreement.

G. "Group" The organization identified as such on the Cover Sheet of this Agreement.

H. "Limitation" Any provision of this Agreement which restricts Benefits, other than an Exclusion.

I. "Member" An eligible employee of Group, the eligible employee's children under the age of 26, persons covered under the eligible employee's health benefit plan, persons residing with the eligible employee, including domestic partners.

J. "Periodic Fees" The monthly amounts due and payable to Plan from Group for providing Benefits to Members.

K. "Plan" Health and Human Resource Center, Inc., doing business as Aetna Resources For Living.

L. "Regulations" Those regulations promulgated and officially adopted under the Act.

M. "Service Area" Those areas of the United States in which Plan is licensed to operate. This includes all areas in the United States where Group employees and their family members are located.

II. CHOICE OF PROVIDERS

Benefits must be obtained from an EAP Provider through Plan. A Member may obtain Benefits by contacting Plan at 1-800-342-8111. Upon contact, Plan will determine the Member's eligibility for Benefits and arrange for Benefits.

III. BENEFITS

Subject to all of the terms, conditions, Limitations and Exclusions of this Agreement, Members are entitled to receive Benefits as follows:

A. Obtaining Benefits. Unless otherwise specifically stated to the contrary, the services described herein are Benefits only if, and to the extent, that they are authorized and directed by Plan and performed by an EAP Provider.

B Non-EAP Providers. In the event Plan fails to pay a non-EAP Provider, the Member will be liable to such non-EAP Provider for the cost of services provided to the Member.

C. Benefits. Benefits may be changed in accordance with Section XII.A hereof.

IV. LIMITATIONS AND EXCLUSIONS

The rights of Members and the obligations of Plan hereunder are subject to the following Limitations and Exclusions:

A. Limitation. In the event of any major disaster or epidemic, Plan shall provide Benefits to Members to the extent practical, according to its best judgment, within the limitations of such facilities and personnel as are then available. Plan shall have no liability to Members for any delay in providing or failure to provide Benefits under such conditions.

B. Exclusion. Court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations, is entirely excluded from Benefits.

V. PERIODIC FEES AND MEMBER CHARGES

A. Periodic Fees. Group shall remit to Plan, by the date specified on the Cover Sheet of this Agreement, the number of employees entitled to receive Benefits as of the effective date of coverage for initial Members also set forth on the Cover Sheet, together with the applicable Periodic Fees set forth on Exhibit B of this Agreement for each such employee. Thereafter, on or before the first day of each month of the term of this Agreement, Group shall provide Plan with the number of employees entitled to receive Benefits during such month, and Plan shall invoice Group for Periodic Fees for such employees. Group shall remit such Periodic Fees to Plan within thirty (30) days of receipt of Plan's invoice therefore for Members entitled to receive Benefits during the month to which the invoice applies. In the event Group fails to timely provide Plan with the number of employees entitled to Benefits during a particular month, Plan may bill Group for Periodic Fees based on the most recent employee count provided by Group and adjust subsequent invoices to reflect any discrepancies accordingly. The Periodic Fees set forth on Exhibit B shall remain in effect for the term of this Agreement, unless changed in accordance with Section XII.A hereof.

B. Other Charges. Plan shall invoice Group for additional services or benefits provided under this Agreement. Group shall remit payment to Plan within thirty (30) days of receipt of each such invoice.

C. Member Charges. Members will not be required to make co-payments to EAP Providers for Benefits. However, a Member is responsible for paying for the services of EAP Providers and others to whom the Member is referred, when the services do not constitute Benefits.

VI. EFFECTIVE DATE OF BENEFITS

A. Initial Members. All employees of Group as of the effective date of this Agreement provided for on the Cover Sheet hereof, and all persons entitled to be Members through such employees shall be entitled to receive Benefits as of 12:01 a.m. on such effective date.

B. Subsequent Members. Any employee who becomes eligible after the effective date of this Agreement and all persons entitled to be Members through the employee, shall be entitled to Benefits, effective immediately. Group shall notify Plan of newly eligible employees.

VII. TERM AND TERMINATION

A. Term. The Initial Term of this Agreement for the provision of Benefits to Members hereunder is set forth on the Cover Sheet of this Agreement. Thereafter, this Agreement shall be automatically renewed for successive twelve (12) month terms ("Renewal Terms"), subject to the termination provisions contained herein.

B. Termination of Individual Member.

1. Loss of Eligibility. If an employee ceases to meet the eligibility requirements of Group, as determined by Group's personnel and benefit policies, then coverage for Benefits under this

Agreement for such employee, and all other Members covered for Benefits through the employee, terminates automatically at midnight on the last day of the month in which the employee ceases to meet the eligibility requirements of Group. Group shall notify Plan monthly of the employees ceasing to meet Group's eligibility requirements. Plan shall not charge an employee who ceases to meet Group's eligibility requirements, or Members covered for Benefits through such employee, for Benefits rendered prior to Group's notice to Plan of the employee's loss of eligibility.

2. Right to Review. A Member who alleges that his or her rights hereunder were terminated or not renewed because of the Member's health status or requirements for Benefits, may request a review of the termination by the Director pursuant to Section 1365(b) of the California Health and Safety Code.

C. Termination of Group.

1. Termination of this Agreement. This Agreement may be terminated by Group, with or without cause, by giving Plan at least thirty-one (31) days advance written notice stating when, after the date of such notice, termination shall become effective. This Agreement may also be terminated by Plan for nonpayment, as provided in Section VII.C.2 and VII.C.3.

2. Nonpayment. If Group fails to pay any amount due Plan within thirty (30) days after Plan's notice to Group of, and bill for the amount due, then Plan may terminate the rights of the Members involved, effective upon Plan's issuance of notification of cancellation to Group. Such rights may be reinstated only by payment of the amounts due and in accordance with Section VII.C.3. Plan shall continue to provide Benefits to Members until expiration of the applicable reinstatement period and shall not charge Members for services rendered during such period. Thereafter, Plan shall not be liable for Benefits to Members.

3. Reinstatement. Receipt by Plan of the proper Periodic Fees within fifteen (15) days of Plan's issuance of the notice of cancellation to Group for non-payment of Periodic Fees shall reinstate the Members as though there never was a cancellation. If such payment is received after said fifteen (15) day period, Plan, at its option, may either refund to Group the amounts paid and consider this Agreement terminated, or issue to Group, within twenty (20) days of the receipt of such payment, a new agreement accompanied by written notice stating clearly those respects in which the new agreement differs from this Agreement in Benefits or other terms.

D. Extension of Benefits upon Termination

1. Termination of Provider Contract. Upon termination of a contract with an EAP Provider, Plan shall be liable for Benefits rendered by such EAP Provider to Members who retain eligibility under this Agreement, or by operation of law, under the care of such EAP Provider at the time of such termination, until the Benefits being rendered to such Members are completed, or until Plan makes reasonable provision for the assumption of such Benefits by another EAP Provider.

2. Group Continuation Benefits. Federal or state law requires Group to continue to make health care benefits available to certain Members who lose eligibility for Benefits under this Agreement. To assist Group in complying with such laws, Plan, in its sole discretion, may agree to continue to make Benefits available to such persons. Under such circumstances, Group shall

be solely responsible for complying with all applicable laws governing such continuation coverage, and for notifying eligible persons of the availability, terms, conditions and duration of, and of all changes in, such coverage. Group agrees to indemnify, save and hold harmless Plan from any and all liability in any way arising out of Group's health care benefit continuation obligations under federal or state law, and Group's notification obligations provided for above.

VIII. COMPLAINT AND GRIEVANCE PROCEDURE

Members are entitled to present complaints and grievances involving Benefits, Plan and EAP Providers to Plan, and Plan is obliged to seek to resolve such complaints and grievances. Plan has established a procedure for processing and resolving Member complaints and grievances. A copy of this procedure, and the form to be used to file a complaint or grievance, are available from Plan and from all EAP Providers and EAP Provider locations.

A grievance is a written or oral expression of dissatisfaction regarding Plan and/or an EAP Provider, including quality of care concerns, and includes a complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative. A complaint is the same as a grievance. There is no discrimination by Plan against a Member for filing a grievance.

Members are entitled to present complaints and grievances. Plan is obliged to seek to resolve such complaints and grievances in a timely fashion. Members may file a grievance up to 365 calendar days following an incident or action that is the subject of the member's dissatisfaction. Plan has established a procedure for processing and resolving Member complaints and grievances.

Should a Member desire to register a complaint or grievance with Plan concerning Benefits, he/she can either call Plan at the toll-free telephone number 1-800-342-8111 to report the complaint or grievance, or to request a copy of Plan's Complaint Form, or write directly to Plan at 10260 Meanley Drive, San Diego, CA 92131. The telephone call or letter should be addressed to the Director, Clinical Quality Improvement. Plan will acknowledge each complaint and grievance within five (5) days of receipt. The Director, Clinical Quality Improvement, will receive and investigate all Member complaints and grievances. The Director, Clinical Quality Improvement, will respond to the Member stating the disposition and the rationale within thirty (30) days of receipt of the grievance. If the grievance is not resolved to the Member's satisfaction, a second level of review may be requested within ten (10) days of notification of such disposition. Any such request will be reviewed by the Medical Director and responded to within seventy-two (72) hours of receipt.

If the complaint or grievance involves a delay, modification, or denial of service related to a clinically emergent or urgent situation, the review will be expedited and a response provided in writing to the Member within three (3) days from receipt of the complaint or grievance. There is no requirement that the Member participate in Plan's grievance process before requesting a review by the California Department of Managed Care ("Department") in any case determined by the Department to be a case involving an imminent and serious threat to the health of the patient, including but not limited to severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the Department determines that an earlier review is warranted. The criteria for determining emergent situations are whether the Member is assessed to be at imminent risk to seriously harm himself or another person, or is so impaired in judgment as to destroy property or be unable to care for his own basic needs. The criteria for determining urgent situations are whether the Member is assessed to be significantly distressed, and

is experiencing a reduced level of functioning due to more than a moderate impairment resulting in an inability to function in key family/work roles.

A Member, or the agent acting on behalf of the Member, may also request voluntary mediation with Plan prior to exercising the right to submit a grievance to the Department. The use of mediation services will not preclude the Member's right to submit a grievance to the Department upon completion of the mediation. In order to initiate mediation, the Member, or the agent acting on behalf of the Member, and Plan will voluntarily agree to mediation. Expenses for the mediation will be borne equally by the parties. The Department will have no administrative or enforcement responsibilities in connection with the voluntary mediation process. Mediations will take place in San Diego, California unless otherwise determined by the parties.

Pursuant to Section 1365(b) of the Act, any Member who alleges his enrollment has been canceled or not renewed because of his health status or requirement for services may request review by the Department.

The California Department of Managed Health Care is responsible for regulating health care service plans. If a member has a grievance against Plan, the member should first telephone Plan at (**1-800-342-8111)** and use Plan's grievance process (or locate Plan's grievance form on their website at **www.mylifevalues.com**) before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to the member. If a member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Plan, or a grievance that has remained unresolved for more than thirty (30) days, the member may call the Department for assistance. The member may also be eligible for an Independent Medical Review (IMR). If the member is 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-HMO-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. Plan's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to the member, and the member's failure to use these processes does not preclude the member's use of any other remedy provided by law.

IX. RECORDS

Plan agrees to maintain, in the State of California, such records and to provide such information to the Director as may be necessary for compliance by Plan with the provisions of the Act and the Regulations. Plan further agrees that such obligations are not terminated upon termination of this Agreement, whether by rescission or otherwise, and that such records shall be retained by Plan for at least five (5) years. Plan agrees to permit the Director access, at all reasonable times upon demand, to such records and information.

X. ARBITRATION

If any dispute or controversy shall arise between the parties with respect to the making, construction, terms, application or interpretation of this Agreement, or the rights of either party, or with respect to any

transaction contemplated by this Agreement, either party may refer the dispute or controversy to the American Arbitration Association for resolution.

The arbitration shall be an adversary hearing and each party shall be entitled to call and cross-examine witnesses under oath and to introduce oral and documentary evidence. The arbitration shall be held within thirty (30) days of the appointment of the arbitrator. The decision of the arbitrator shall be final and binding. Judgment on the award may be entered in any court having jurisdiction and shall be fully binding on the parties.

The arbitration shall take place in San Diego, California, unless some other location is mutually agreed upon by the parties, and shall be governed by the rules of the American Arbitration Association, except as may otherwise be expressly provided herein. The expenses of the arbitrator shall be shared equally by the parties. The prevailing party in the arbitration or in any legal action concerning the arbitration or the judgment on the arbitration award, shall be entitled to recover its costs and reasonable attorney's fees from the other party.

XI. HIPAA COMPLIANCE

Each party acknowledges that the use and disclosure of individually identifiable health information is limited by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any current and future regulations promulgated thereunder including without limitation the federal privacy regulations contained in 45 CFR Parts 160 and 164, the federal security standards contained in 45 CFR Part 160, 162 and 164 and the federal standards for electronic transactions contained in 45 CFR Parts 160 and 162, all collectively referred to herein as the HIPAA Requirements. Each party agrees to comply with the HIPAA Requirements to the extent applicable to such party and further agrees that it shall not use or further disclose Protected Health Information (as defined under the HIPAA Requirements) other than as permitted by the HIPAA Requirements. The parties further agree to execute such other agreements and understandings as may be necessary or required to satisfy all HIPAA Requirements applicable to this Agreement and the transactions contemplated hereby.

XII. MISCELLANEOUS

A. Change of Periodic Fees and/or Benefits. Plan may change Periodic Fees and/or Benefits hereunder, effective thirty (30) days after receipt by Group of written notice from Plan setting forth any such change, but in no event during the term of the Agreement then in effect.

B. Member Consent. By this Agreement, Group makes Benefits available to Members. However, this Agreement shall be subject to amendment, modification or termination, in accordance with the provisions hereof, or by mutual agreement between Plan and Group, without the consent or concurrence of Members. By electing Benefits pursuant to this Agreement, or accepting Benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions hereof.

C. Entitlement to Benefits. To be entitled to receive Benefits under this Agreement, a person must be a Member on whose behalf Periodic Fees have been paid. Any person receiving Benefits to which he or she is not then entitled pursuant to the provisions of this Agreement shall be responsible for payment therefore.

D. Notice of Certain Events. Plan shall give Group written notice within a reasonable time of any termination or breach of contract by, or inability to perform of an EAP Provider, or any person with whom Plan has a contract to provide Benefits hereunder, if Group can be materially and adversely affected thereby.

E. Liability of Plan. In the event Plan fails to pay EAP Providers for Benefits provided to Members, Members shall not be liable to EAP Providers for any sums owed by Plan.

F. Member's Liability to Non-Plan Providers. Except with respect to Benefits rendered in an emergency, in the event Plan fails to pay non-EAP Providers, Members may be liable to such non-EAP Providers for the cost of services rendered.

G. Plan Referrals to Members. When EAP Providers refer Members for further treatment, EAP Providers, to the best of their ability, will inform Members of the insurance deductibles and co-payments that Members will be liable for as a result of the referral. Members will be informed they are fully liable for all costs of treatment subsequent to the Benefits provided herein.

H. Plan's Policies. Plan may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration of this Agreement.

I. Entire Agreement. This Agreement, including its Exhibits, constitutes the entire understanding between the parties with respect to the subject matter hereof and, as of the effective date hereof, supersedes all other agreements between the parties with respect to such subject matter. If any part of this Agreement is deemed unenforceable, the remaining parts shall remain in full force and effect.

J. Amendments. No agent or other person, except an authorized representative of Plan, has authority to waive any condition or restriction of this Agreement, to extend the time for making a payment, or to bind Plan by making any promise or representation or by giving or receiving any information. No change in this Agreement shall be valid unless evidenced by an endorsement to it signed by the aforesaid representative, or by an amendment to it signed by Group and such representative of Plan. The above notwithstanding, this Agreement shall be deemed automatically amended to comply with the provisions of the Act and the Regulations.

K. Notices. Any notice under this Agreement may be given, addressed to the applicable party at the address provided on the Cover Sheet, or to such other address as may be provided by giving notice pursuant to this Section. Notices given by United States mail, postage prepaid, return receipt requested shall be deemed given three (3) days after deposit in the mail. Notices given by next day or overnight delivery or in person shall be deemed given upon delivery.

L. Notices to Members. Group agrees to disseminate all notices regarding material matters with respect to this Agreement and Plan to Members within ten (10) days after the receipt of notice of such matters from Plan. In the event that any such notice from Plan involves the cancellation or termination of, or decision not to renew this Agreement, Group shall provide notice of such to Members promptly and shall provide Plan with written evidence of such notification.

M. Discrimination. Plan may not refuse to enter into any contract, or cancel or decline to renew or reinstate any contract, nor may Plan modify the terms of a contract because of the race, color,

national origin, ancestry, religion, sex, marital status, sexual orientation, handicap or age of any contracting party, or person reasonably expected to benefit from such contract.

N. Headings. The headings of the Articles and Sections of this Agreement are for information purposes only and shall not limit or otherwise restrict the meaning of any provision of this Agreement.

O. Interpretations and Governing Law.

1. Plan is subject to the requirements of the Act and the Regulations, and any provision required to be in this Agreement by either of the above shall bind Plan whether or not set forth herein.

2. This Agreement shall be governed by and construed in accordance with the laws of the State of California.

P. Limitation on Liability. Group acknowledges that the information and advice provided to Members by legal and financial persons to whom Members are referred under this Agreement ("Referees") are not, expressly or impliedly, endorsed, recommended or approved by Plan. The relationship between Plan and a Referee is that of independent third party entities. Plan, its agents and affiliates are not agents or affiliates of any Referee. Referees maintain a Referee-client relationship with Members, and Referees are solely responsible to Members for any and all services that they may provide to Members. Plan makes no warranties, expressed or implied, of any kind with respect to the services provided by a Referee. Plan shall not be liable for the negligence or wrongful acts or omissions of Referees.

EXHIBIT A

DESCRIPTION OF SERVICES

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Subject to the terms and conditions of this Services Agreement, the EAP Services selected by Group and provided by Plan are reflected in this **EXHIBIT A: DESCRIPTION OF SERVICES** and **SERVICE AND FEE SCHEDULE**. Additional EAP Services may be provided at Group's request under the terms of this Services Agreement. All Services described in this Services Agreement are available within the United States only. International EAP Services are only available if specifically described and priced separately.

1. UNLIMITED TELEPHONIC ASSESSMENT AND REFERRAL: Unlimited telephonic access to the EAP call center staff, available 24 hours per day, 7 days per week, 365 days per year for purposes of assessing member needs and referring to appropriate EAP Services.

2. COUNSELING SESSIONS: A clinical session with an EAP Behavioral Health Professional. Sessions are intended to assist with emotional, family, personal, or work related behavioral health issues.

   FACE-TO-FACE COUNSELING SESSIONS: A face-to-face clinical session with an EAP Network Provider. Each member is entitled, on a contract year, up to the allowed number of counseling sessions per incident as set forth herein under Exhibit B. Face-to-face counseling sessions require prior authorization. The member must contact Plan to receive referrals and an authorization to a contracted EAP Network Provider. Marital and/or family sessions are considered one problem for the couple or family and sessions are not authorized individually for each attendee.

3. EAP PROVIDER NETWORK: A nationwide network of licensed behavioral health professionals, who meet all Plan credentialing standards, and who are contracted by Plan, as independent contractors, to provide counseling to Members. EAP Network Providers include, but are not limited to: social workers, licensed professional counselors, marriage and family therapists, master's level psychiatric nurses and psychologists.

4. TRAINING AND EDUCATION: The term "Training and Education" refers to training, provided by Plan, or a Plan Contracted educator to the Group, concerning general behavioral health and work/life issues. This includes Employee Orientation Meetings and Supervisor Orientation Trainings. This training may be provided in different ways, i.e. in-person, telephonically, or web-based (webinars). Additional fees apply to webinars with over 25 participants (participants are defined as unique phone lines calling into the webinar). Department of Transportation (DOT) services are excluded from standard Training and Education services. For specialized DOT training, see separate definition under Drug Free Workplace Services.

5. MANAGEMENT SERVICES:

   - MANAGEMENT CONSULTATION: A telephonic resource for managers, supervisors, and human resources professionals to assist in identifying and resolving workplace issues and promoting a productive workforce. Issues may include but are not limited to employee personal and family issues, behavioral health concerns, workplace conflict, workplace crisis and other disruptions, substance abuse, threats of violence and employee performance

concerns. This includes the provisions of guidance to the Group in making voluntary referrals for employees to the EAP. EAP will coordinate with specialty providers as needed (SAP, DOT, FFD).

- MANDATORY REFERRALS: Case management to assist Group and employees in addressing significant workplace performance issues. Mandatory referrals are used to monitor compliance with the EAP Behavioral Health Professional's recommendations, wherein the EAP, with appropriate executed release of information forms, confirms the employee's participation in and compliance with the Program.

- DRUG FREE WORKPLACE SERVICES: Suite of services to assist Group in managing workplace related employee substance misuse and/or disclosure of substance abuse in the workplace. Services for general employer industries include Plan EAP case management of mandatory referrals related to workplace impacted substance abuse, as well as management consultation services as described above. Services for transportation related industries, such as employers who are regulated by DOT, FMCSA, FAA, FRA, FTA, PHMSA, etc., include substance abuse case management by a Substance Abuse Professional (SAP) for Department of Transportation regulation compliance. Additional service for transportation regulated employees includes DOT training to meet Drug-Free Workplace regulations regarding drug and alcohol awareness available through American Substance Abuse Professionals (ASAP) or comparable SAP provider. A variety of training formats are available, including on-site, on-line or video.

- FITNESS FOR DUTY (FFD) CONSULTATION AND COORDINATION: A Fitness for Duty Evaluation is a forensic evaluation completed by a specially trained psychologist, psychiatrist, outside the EAP, for the purpose of evaluating an employee's ability to safely perform the functions of their job, assess organizational and behavioral risk, and provide a report recommending steps needed to be taken to minimize Group risk in returning the employee to work. Fitness for Duty Evaluations are outside the scope of EAP, and as such the EAP does not conduct Fitness for Duty Evaluations. Upon specific request, the EAP may assist Group with locating companies or providers external to the EAP who are capable of performing FFD Evaluations. At all times the Group is responsible for working directly with the identified FFD provider as well as directly making payment arrangements with that provider for the FFD Evaluation. All decisions, regarding returning to work, retaining or dismissing employees remain with the Group.

- SUBSTANCE ABUSE PROFESSIONAL (SAP) CONSULTATION AND CONTACT INFORMATION: Upon request of Group, for drug and alcohol cases that fall under the Department of Transportation (DOT) guidelines, Plan shall provide initial and ongoing management consultation on DOT issues. Plan will further provide contact information of local providers in our specialized network of qualified Substance Abuse Professionals. Group is responsible for choosing and working directly with the SAP, as well as performing Follow-up, Compliance and Aftercare attendance monitoring. Group is responsible for payment of the SAP and determines whether the employee or employer pays SAP fees as well as recommended treatment costs.

6. CRITICAL INCIDENT SUPPORT (Crisis Support/Management Services/Critical Incident Stress De-Briefing (CISD) Services): An array of services offered by the EAP that helps an organization to

prepare for, prevent, or respond to traumatic events. Acts of war are excluded from on-site CISD Services.

- ON-SITE STANDARD CRITICAL INCIDENT SUPPORT: On-site attendance response time in greater than two hours for hourly onsite crisis support and Critical Incident Stress De-Briefing (CISD) Services at Group sites to help an organization prepare for, prevent, or respond to traumatic events.

- ON-SITE IMMEDIATE CRITICAL INCIDENT SUPPORT: On-site attendance response time in less than two hours for hourly onsite crisis support and Critical Incident Stress De-Briefing (CISD) Services at Group sites to help an organization prepare for, prevent, or respond to traumatic events.

7. REDUCTION IN FORCE: The process by which a work organization reduces its work force by eliminating jobs, such as closing subsidiaries or departments.

8. COMMUNICATION AND PROMOTIONAL MATERIALS: Information provided to Employees and management about EAP Services, including, in part, how EAP Services can be accessed for consultation and assistance. The communications and promotional resources may include template e-mails, letters, flyers, wallet cards, and posters for Employees and management. Plan will provide reasonable quantities of printed materials in support of implementation and/or on an annual basis at Group's request at no cost. Reasonable quantities are defined as up to 120% of the number of eligible Employees for items such as flyers or brochures; a quantity up to 5% of the number of eligible Employees for items such as posters; and a quantity of up to 20% of anticipated attendees at health fairs for other promotional items. Requests exceeding these quantities may incur an additional fee.

9. MANAGEMENT REPORTS: A specific collection of data and narrative information designed to inform Group about the overall utilization of the program. Group may receive reports on an electronic basis. If for any two consecutive reporting periods there is less than 1% utilization, reporting frequency will default to annual reporting.

10. INTAKE MODEL:

    - STANDARD MODEL: Initial intake calls answered by a care service associate /customer service representative.

11. EAP EXCLUSIONS**:** The following services are outside the scope of the EAP:

    - Counseling services beyond the allowed number of sessions covered by the EAP benefit.
    - Court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, custody, or visitation evaluations, or paid for by Workers' Compensation.
    - Formal psychological evaluations which normally involve psychological testing and result in a written report.
    - Diagnostic testing and/or treatment.
    - Visits with psychiatrist, including medication management.
    - Prescription medications.

- Services for remedial education.
- Inpatient treatment of any kind, residential treatment, partial hospitalizations, intensive outpatient treatment.
- Ongoing counseling for a chronic diagnosis that requires long term care.
- Biofeedback.
- Hypnotherapy.
- Aversion therapy.
- Examination and diagnostic services required to meet employment, licensing, insurance coverage, travel needs.
- Services with a non-contracted EAP Provider.
- Fitness for duty evaluations.
- Legal representation in court, preparation of legal documents, or advice in the areas of taxes, patents, or immigration, except as otherwise described in this document.
- Investment advice (nor does Plan loan money or pay bills).

WORK/LIFE PROGRAM SERVICES

1. WEB-BASED CAREGIVING SERVICES: Services that include information and education in connection with, in part, adoption, child care, parenting, temporary back-up care, summer care, special needs, high-risk adolescents, academic services, education loans, grandparents as parent, adult care, elder care, and disaster resources.

2. WEB-BASED PERSONAL SERVICES: Free educational materials and interactive web tools to assist with:

    - Health & Wellness--Children's health; women's health; men's health; seniors' health; weight loss and nutrition; fitness and exercise programs; general health; safety; stress management; information on diseases and conditions; and more.

    - Daily Life--Home improvement; pet care; consumer information; automotive services; relocation; travel; time management; cleaning services; and more.

3. LEGAL, FINANCIAL, and IDENTITY THEFT SERVICES: Services provided through the EAP that include:

    LEGAL SERVICES:

    - ½ hour Initial Consultation with selected participating attorney on an unlimited number of new Legal Topics (each plan year). Certain topic areas are excluded, including employment law. Also excluded are matters that, in the attorney's opinion, lack merit. Court costs, filing fees and fines are the responsibility of the member. If members choose to continue with the participating attorney and hire that attorney on their own, they will receive 25% off of the fees for services beyond the initial consultation (excluding flat legal fees, contingency fees, and plan mediator services).

    - Mediation Services – Each member is entitled to one (1) initial thirty minute office or telephone consultation per separate legal matter at no cost with a participating mediator. In the event that the member wishes to retain a participating mediator after the initial consultation, they will be provided with a preferred rate reduction of 25% from the mediator's normal hourly rate. Typical matters may include divorce and child custody, contractual and consumer disputes, real estate and landlord tenant, car accidents and insurance disputes.

    - Document Preparation: Members have access to telephonic document preparers and an on-line assisted process to complete their own legal document preparation. Member's will receive a preferred discount of 10% off and the types of forms include, divorce, wills, living wills, powers of attorney, immigrations and others.

    - Simple Will Preparation: Members receive resources to complete one Simple Will.

    - All initial consultation (and discounted consultations) must be for legal matters related to the Employee and eligible household members.

    FINANCIAL SERVICES:

- ½ hour Initial Consultation with the selected participating financial counselor on an unlimited number of new Financial Counseling Topics each plan year.

- Financial counseling topics include Budgeting, Credit, Debt, Retirement, College Planning, Buying vs. Leasing, Mortgages/Refinancing, Financial Planning, Tax Questions, Tax Preparation, IRS Matters, Tax Levies and Garnishments, Consumer Credit Counseling, and Community Services.

- A discount of 25% off the tax preparation services.

- Individual Employees may have the option to purchase additional services for a monthly nominal fee.

IDENTITY THEFT SERVICES:

- 1-hour telephonic fraud resolution consultation for Identity Theft.

- Coaching and direction on prevention and restoring credit for victims of Identity Theft.

- Free Identity Theft Emergency Response Kit for victims of Identity Theft.

- Individual Employees may have the option to purchase additional services for a monthly nominal fee.

4. MEMBER WEBSITE:

CORE MEMBER WEBSITE: Access to customizable member website for free webinars, online work/life searches, concierge database, discount program, thousands of articles, videos, and tools on work/life and behavioral health topics.

DOMESTIC EAP GROUP SERVICE AND FEE SCHEDULE

Group hereby elects to receive the Services designated below. The below Service Fees shall be in effect for the Initial Term of Agreement as specified on the Cover Sheet of this Agreement, and, thereafter, if this Services Agreement is renewed for any additional successive Term(s), such Service Fees may be revised for each such successive Term.

CRITICAL INCIDENT SUPPORT/CRITICAL INCIDENT STRESS DE-BRIEFING (CISD) SERVICES:

STANDARD CISD SERVICES (On-site attendance response time in greater than two (2) hours.)

Fee-For-Service: $250.00 per hour plus travel and preparation expenses reimbursed at a flat rate of $150.00 per location.

Cancellation: Whenever possible, Group agrees to provide Plan with 24 hours advance notice of cancellation of any requested Workplace Crisis Response Services. Failure to provide Plan with 24 hours advance notice of cancellation of services which are provided on a fee-for-service basis and which are subject to the hourly fee-for-service rate will result in a charge of $375.00 per incident.

IMMEDIATE CISD SERVICES (On-site attendance response time in two (2) hours or less.)

Fee-For-Service: $350.00 per hour plus travel and preparation expenses reimbursed at a flat rate of $150.00 per location.

Cancellation: Services which are provided on a fee-for-service basis and which are subject to the hourly rate will result in a charge of $375.00 per incident.

CISD hours used, whether fee-for-service and/or within a bank of Standard CISD hours included, are calculated based upon the combined total number of hours all clinicians are on-site.

If Group requests a specific crisis counselor, or a counselor with specific qualities, including but not limited to specialized certifications, experience, or language, Group will be billed the applicable hourly rate "door-to-door" which will include the specialist's travel time. This is in lieu of the flat preparation time and travel fee.

If Group requests on-site crisis response services in a location which is further than 50 miles from a town with a population of at least 25,000 people, Group will be billed the applicable hourly rate "door-to-door" which will include the specialist's travel time. This is in lieu of the flat preparation time and travel fee.

If Group requests on-site support services in response to a large scale disaster area affecting the transportation infrastructure of that area, and/or the availability of local providers, necessitating the assistance of providers from outside the affected areas, Group will be billed the current hourly rate plus $50 per hour for each on-site hour. In addition, Group will be billed $200 per travel hour from the command center to the intervention site. This is in lieu of the flat preparation time and travel fee.

Any other Group requested services wherein the crisis counselor incurs non-standard travel (e.g. having to fly to accompany employees affected by a crisis) will be billed at the exact travel costs in addition to the hourly fees.

REDUCTION IN FORCE (RIF) SERVICES:

Fee-For-Service: $250.00 per hour plus travel and preparation expenses reimbursed at a flat rate of $150.00 per location.

Cancellation: Group agrees to provide Plan with 24 hours advance notice of cancellation of any requested RIF service. Failure to provide Plan with 24 hours advance notice of cancellation will result in a charge of $375.00 per incident.

TRAINING AND EDUCATION SERVICES:

Orientations: Employee Orientation Meetings and Supervisor Orientation Trainings are included at no cost to Group.

Bank of Training and Education Hours: Included is a bank of six (6) hours of Training and Education (other than Orientations). Training and Education services may be on-site, or for web-based seminars up to 25 participants. For webinars with more than 25 participants, an additional charge of $50.00 applies for each additional 25 participants up to a maximum of 200 participants.

Additional Training and Education sessions are $250.00 per hour for the total amount of time that the educator is on-site, plus travel and preparation expenses reimbursed at a flat rate of $150.00 per location. If training is not scheduled consecutively, or multiple topics are scheduled, additional travel and preparation costs may apply, or additional hours may be deducted from the bank. These capitated hours will be used for the total amount of time that the educator is on-site.

Sessions less than one (1) hour in duration will count as one (1) hour of Training and Education.

If Group requests a specific educator, or an educator with specific qualities, including but not limited to specialized certifications, experiences or language, Group will be billed any additional incurred fees beyond those listed above, or have hours deducted from bank.

In addition, if Group cannot accommodate the schedule/availability of a local Plan contracted educator, requiring that the services of an educator 50 miles away or greater from the Group location is necessary, then Group will be billed any additional incurred fees beyond those listed above, or have hours deducted from bank.

Cancellation: Group agrees to provide Plan with at least three (3) business days advance notice of cancellation of a previously scheduled Training and Education Service. Failure to provide Plan with at least three (3) business days advance notice of cancellation of previously scheduled services which are included in the Bank of Training and Education Hours will result in the deduction of a number of hours from the Bank equal to the number of hours cancelled. When the bank of hours has been exhausted, fee-for-service cancellation fee of $375.00 per cancelled hour of service applies.

DRUG-FREE WORKPLACE SERVICES:

DEPARTMENT OF TRANSPORTATION (DOT) TRAINING TO MEET DRUG-FREE WORKPLACE REGULATIONS REGARDING DRUG AND ALCOHOL AWARENESS:

SUPERVISOR TRAINING: Alcohol and Drug-Free Workplace Training to meet Drug-Free Workplace regulations regarding drug and alcohol use.

Fee-For-Service: $800.00 per two-hour DOT Supervisor Training.

Additional fees may be added on to the base rate for DOT training. These fees will be assessed on a case-by-case basis and are dependent upon travel expenses and for classes that exceed 50 participants.

EMPLOYEE TRAINING: Alcohol and Drug-Free Workplace Awareness (Note: this training does not meet Drug-Free Workplace regulations regarding drug and alcohol use.)

Fee-For-Service: $400.00 per one-hour DOT Employee Training.

Additional fees may be added on to the base rate for DOT training. These fees will be assessed on a case-by-case basis and are dependent upon travel expenses and for classes that exceed 50 participants.

SUBSTANCE ABUSE CASE MANAGEMENT:

Case Management of Substance Abuse Professional (SAP)/DOT cases.

Included: Case Management of Substance Abuse Professional (SAP)/DOT cases are included at no cost to Group.

EXHIBIT B

Periodic Fees

$1.79 Per Employee Per Month.

This rate includes the following services, more fully documented in Exhibit A and the Agreement:

Service	Rate
Eight-session Employee Assistance Program	$ 1.79 per employee per month

Additional services not specifically covered by this contract will be billed at then current rates.

EMPLOYEE ASSISTANCE PROGRAM
COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

TABLE OF CONTENTS

HEALTH AND HUMAN RESOURCE CENTER
(dba AETNA RESOURCES FOR LIVING)
10260 Meanley Drive
San Diego, CA 92131
1-800-342-8111

EMPLOYEE ASSISTANCE PROGRAM

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

The Employee Assistance Program (EAP) is being offered by your employer to provide you with confidential assistance from licensed mental health professionals. These professionals can help with problems affecting your life at work as well as at home. Such problems include marital issues, family relationships, depression and anxiety, alcohol and drug issues, and/or problems within the workplace.

The EAP counselors will conduct a thorough assessment of your problem and together with you will decide on an action plan that will either resolve the issue within the EAP sessions or will refer you to appropriate providers and/or community resources that have been reviewed by the EAP. Your involvement with the EAP counselor will be at no cost to you.

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health plan. The EAP Services Agreement must be consulted to determine the exact terms and conditions of coverage. A copy of the agreement will be furnished on request and is available from your employer.

This Combined Evidence of Coverage and Disclosure Form discloses the terms and conditions of coverage. It also provides you with important information on how to obtain Benefits and the circumstances under which Benefits will be provided to you. **PLEASE READ IT CAREFULLY.** Individuals with special health care needs should read carefully those sections that apply to them.

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

Contact Plan at 1-800-342-8111 to receive additional information about Benefits.

Enclosed as Exhibit B is Plan's matrix of covered services.

EAP plans - **IMPORTANT:** Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call right away at 1-877-287-0117.

Planes EAP - **IMPORTANTE:** ¿Puede leer esta documento? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta documento escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

I. DEFINITIONS

The following terms have the following meanings for purposes of this Combined Evidence of Coverage and Disclosure Form.

A. "Act" means the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code, Sections 1340 et seq.).

B. "Benefits" means the services to which Members are entitled under an EAP Services Agreement, and which are described in Exhibit A to this Combined Evidence of Coverage and Disclosure Form.

C. "EAP Provider" means the licensed assessment and short-term counseling mental health professionals employed by, or under contract with, Plan to provide Benefits to Members.

D. "EAP Services Agreement" means the Employee Assistance Program (EAP) Services Agreement between Plan and Group, which establishes the terms and conditions governing the provision of Benefits to Members by Plan.

E. "Exclusion" means any provision of an EAP Services Agreement whereby coverage for Benefits is entirely eliminated, and which is set forth in Exhibit A to this Combined Evidence of Coverage and Disclosure Form.

F. "Plan" means Health and Human Resource Center, Inc., doing business as Aetna Resources For Living.

G. "Group" means the company that has entered into an EAP Services Agreement with Plan for Plan to provide Benefits to Members.

H. "Limitation" means any provision of an EAP Services Agreement, other than an Exclusion, which restricts Benefits, and which is set forth in Exhibit A to this Combined Evidence of Coverage and Disclosure Form.

I. "Enrollee" means any eligible employee of Group who (1) resides in California and (2) may be covered under the Act.

J. "Member" means an Enrollee covered by Group, as defined above, the Enrollee's children under the age of 26, persons covered under the Enrollee's health benefit plan, and persons residing with the Enrollee, including domestic partners of the same or opposite sex.

K. "Periodic Fees" means the monthly amounts due and payable to Plan by Group for providing Benefits to Members.

L. "Emergency Services" means medically necessary transport using the 911 system or medical screening, examination and evaluation by a physician to determine if an emergency medical condition or psychiatric emergency medical condition exists.

M. "Crisis Intervention" means assessment and problem solving in situations which you feel require immediate attention. Crisis intervention is available 24 hours per day, 7 days a week by telephone, and face to face by appointment. To access, call 1-800-342-8111.

N. "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 by the Member to result in any of the following:

- Placing the Member's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

II. HOW TO OBTAIN BENEFITS

Unless otherwise provided herein, you are entitled to Benefits from an EAP Provider. You must obtain Benefits by calling 1-800-342-8111. Upon contact, Plan will determine your eligibility for Benefits and arrange for Benefits.

All Benefits must be provided by Plan or by an EAP Provider referred to by Plan. Local and toll-free telephone numbers are available to access Benefits. Appointments with EAP Providers are readily available and, depending on your desire for a particular time and location, most appointments are offered within forty-eight (48) hours of contact.

Plan does not directly provide specialty services beyond assessment, brief counseling and/or referral. Plan's role in the referral process is to function as an advocate for you to obtain necessary and appropriate levels of care; usually under your group health plan. Your EAP Provider will assist you in securing potential referral resources.

During or after business hours, any Member may access a licensed mental health professional for a telephone assessment. The telephone assessor may provide crisis intervention over the telephone, arrange a same-day appointment with an EAP Provider in your area, or assist you in obtaining more intensive, acute care services.

III. EMERGENCY SERVICES

Emergency services are medically necessary ambulance and ambulance transport services provided through the 911 emergency response system and medical screening, examination, and evaluation by a physician, or other personnel, to the extent provided by law, to determine if an Emergency Medical Condition or psychiatric emergency medical condition exists; and, if it does, the care, treatment, and/or surgery by a physician necessary to relieve or eliminate

the Emergency Medical Condition or psychiatric emergency medical condition within the capabilities of the facility.

What To Do When You Require Emergency Services

If you believe that you need Emergency Services, you should call 911 or go to the nearest emergency medical facility for treatment. Plan does not cover emergency medical services.

It is appropriate for you to use the 911 emergency response system, or alternative emergency system in your area, for assistance in an emergency situation described above when ambulance transport services are required and you reasonably believe that your condition is immediate and serious and requires emergency ambulance transport services to transport you to an appropriate facility

IV. CRISIS INTERVENTION

If you need crisis intervention or problem solving, call Plan at 1-800-342-8111. Plan provides crisis intervention both during and after business hours at this number. A member who is currently outside Plan's service area and requires this service can call 1-800-342-8111. Members can obtain care if they are temporarily outside of Plan's service area. Members can also be scheduled for an appointment on an urgent basis following assessment by a licensed clinician over the telephone

V. PERIODIC FEES

Plan bills Group for Periodic Fees and Group remits such fees to Plan each month during the term of the EAP Services Agreement for Members entitled to receive Benefits during such month. Plan may change the Periodic Fees and/or Benefits under the EAP Services Agreement, effective thirty (30) days after receipt by Group of written notice from Plan setting forth any such change, but in no event during the then-existing thirty-six (36) month term of the EAP Services Agreement. There are no co-payments, deductibles, or charges to you for Benefits.

VI. OTHER CHARGES

Plan will bill Group for additional services or benefits provided under the Agreement. Group will remit payment to Plan within thirty (30) days of receipt of invoice.

VII. PREPAYMENT OF FEES

The Member does not pay co-payments, deductibles, or fees for Plan. All fees are paid by Group.

VIII. CHOICE OF EAP PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS BENEFITS MAY BE OBTAINED: You will be referred to an EAP Provider in accordance with your clinical, appointment time, and location needs. You should call Plan at 1-800-342-8111 to determine the names and locations of EAP Providers.

EAP contracted providers include licensed psychologists, licensed clinical social workers, and licensed marriage and family therapists. Psychiatrists are not provided through the EAP. Members are given names of contracted providers in their area with knowledge in the problem area that is indicated. You may also request a list of providers, and this will be provided for the geographic area, customized by specialty, if you prefer.

IX. FACILITIES

The location of Providers is obtained by calling Plan at 1-800-342-8111. If you prefer, a customized list of providers will be provided upon request. This is arranged by zip code in the area specialty that you request.

X. LIABILITY OF PLAN / MEMBERS

A. Liability of Plan

In the event Plan fails to pay EAP Providers for Benefits provided to you, you shall not be liable to EAP Providers for any sums owed by Plan.

B. Liability of Members

It is not contemplated that Members would make payment to Plan providers for benefits. If this has occurred, the Member may contact Plan at 1-800-342-8111 to be reimbursed. There is no restriction on assignment of sums payable to the Member by the health plan.

C. Member Liability to Non-EAP Providers

You may be liable to non-EAP Providers for the cost of services rendered when such services are not authorized or referred by Plan.

XI. PROVIDER COMPENSATION

Plan compensates EAP Providers through an agreement by which they are paid a fixed amount of money based on hours worked, number of Members seen, or number of sessions provided. Providers are compensated within thirty (30) days after claim is received.

Plan does not distribute financial bonuses or use any other incentive program to compensate its EAP Providers other than the methods of compensation defined above.

Members may request further information about Plan's EAP Provider reimbursement policies and procedures by contacting Plan's Manager, Provider Relations, at 1-800-342-8111 or the Member's EAP Provider.

XII. SECOND OPINION POLICY

You may request a second opinion regarding both treatment recommended by the treating EAP Provider and treatment desired by you. Plan will authorize second opinions where the second opinion is consistent with professionally recognized standards of practice. The second opinion request will not result in a change in what is and is not a Benefit as described in the EAP Services Agreement and this Combined Evidence of Coverage and Disclosure Form. Plan may deny coverage for second opinion requests for services not listed as Benefits in the EAP Services Agreement and this Combined Evidence of Coverage and Disclosure Form. If Plan denies such a request, you will bear the financial responsibility for any self-directed second opinion. There will be no cost to you if the second opinion is received from an EAP Provider under contract with Plan. If you request a second opinion from a provider not under contract with Plan, you must provide an explanation as to why an EAP Provider cannot render such an opinion. Plan's Medical Director shall review the request to determine whether there is an EAP Provider qualified to render a second opinion.

Requests for second opinions may be made by contacting the Director, Clinical Quality Improvement at (1-800-342-8111) or in writing to 10260 Meanley Drive, San Diego, CA 92131. All requests for second opinions shall be processed and approved or denied by Plan within five (5) business days of receipt. Requests related to urgent care or crisis intervention shall be processed and approved or denied within forty-eight (48) hours of receipt.

XIII. ELIGIBILITY/ENROLLMENT/EFFECTIVE DATE OF COVERAGE

All Enrollees identified by Group prior to the effective date of the EAP Services Agreement and all persons covered under the identified Enrollee's health benefit plan or residing with the identified Enrollee shall be entitled to Benefits as of such effective date. Group shall be responsible for notifying Plan of any Enrollee who becomes newly eligible after the effective date of the EAP Services Agreement. Plan shall rely upon the determination by Group as to which Enrollees are eligible for Benefits under the EAP Services Agreement. Any disputes or inquiries regarding eligibility, including rights regarding renewal, reinstatement and the like, shall be referred by Plan to Group, which shall then advise Plan of its determination with respect to the matter.

XIV. TERMINATION OF BENEFITS

Usually, your enrollment in the plan terminates when Group or Enrollee is no longer eligible for coverage under the employer's EAP plan. In most instances, Group determines the date in which coverage will terminate. Coverage can be terminated, however, because of other circumstances as well, which are described below.

A. Cancellation of Group Contract for Nonpayment of Premiums

Continuing coverage under this EAP Plan is subject to the terms and conditions of Group's EAP Services Agreement with Plan. If the EAP Services Agreement is cancelled because Group failed to pay the required premiums when due, then coverage for you and all your dependents will end 15 days after Group mails you the Notice Confirming Termination of Coverage.

Plan will mail your Group a notice at least 30 days before any cancellation of coverage. This Prospective Notice of Cancellation will provide information to your Group regarding the consequences of your Group's failure to pay the premiums due within 15 days of the date the notice was mailed.

If payment is not received from Group within 15 days of the date the Prospective Notice of Cancellation is mailed, Plan will mail Group a Notice Confirming Termination of Coverage, which Group will then forward to you. This notice will provide you with the following information:

1) That Group's EAP Services Agreement has been cancelled for non-payment of premiums;

2) The specific date and time when Group coverage ends, which will be no sooner than 15 days after the Notice Confirming Termination of Coverage is mailed to you.

B. Reinstatement of the Contract after Cancellation

If Group's EAP Services Agreement is cancelled for Group's nonpayment of premiums, then Plan will permit reinstatement of Group's Agreement if Group pays the amounts owed within 15 days of the date of the Notice Confirming Termination is mailed to Group.

C. Member Termination for Non-Eligibility

In addition to terminating the EAP Services Agreement, Plan may terminate a Member's coverage for any of the following reasons:

- Member no longer meets eligibility requirements established by Group and/or Plan;
- Member lives or works outside Plan's Service Area and does not work inside Plan's Service Area (except for a child who is covered as a dependent).

<u>Ending Coverage – Special Circumstances for Enrolled Family Members</u>.
Enrolled Family Members terminate on the same date of termination as Group. If there is a divorce, the Spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered. Dependent children lose their eligibility when they reach the Limiting Age of 26 and do not qualify for extended coverage as a disabled dependent.

D. Termination for Good Cause

Plan has the right to terminate your coverage under this EAP Plan in the following situation:

- Fraud or Misrepresentation. Your coverage may be terminated if you knowingly provide false information (or misrepresent a meaningful fact) on your enrollment form or fraudulently or deceptively use services or facilities of Plan and/or Plan's participating Providers (or knowingly allow another person to do the same). Termination is effective immediately on the date Plan mails the Notice of Termination, unless Plan has specified a later date in that notice.

If coverage is terminated for the above reason, you forfeit all rights to enroll in the COBRA Plan.

Under no circumstances will a Member be terminated due to health status or the need for EAP Services. Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for EAP Services may request a review of the termination by the California Department of Managed Health Care. For more information, contact our Customer Service Department.

NOTE: If the EAP Services Agreement is terminated by Plan, reinstatement with Plan is subject to all terms and conditions of the EAP Services Agreement between Plan and the employer.

XV. CONTINUITY OF CARE

A. New Members

1) Eligibility

Any newly covered Member with an acute, serious, chronic, or other mental health condition who has been receiving services from a licensed mental health provider who is not on Plan's panel is eligible for continuation of care. This does not include the services of psychiatrists, as the EAP benefit does not include psychiatric care. If you are newly covered under the EAP, you will be offered the option of continued care with your non-plan provider through the EAP. The Manager of Provider Relations or the Director of Clinical Services will review all requests for continued care with a non-plan provider. Consideration will be given to the potential clinical effect that a change of provider would have on your treatment for the condition. Notification of the referral acceptance is by telephone and a referral confirmation to the provider. If the provider declines to provide services, you will be notified in writing.

2) Access

You may access the services of the provider by calling Plan and indicating to the intake person that you have an ongoing client-patient relationship with the Provider.

You then should ask the Provider to call and provide information to Provider Relations to be added to the panel for you. The non-plan provider must agree to continue until one of the following occurs:

a. The episode of care is completed.

b. Your benefit is exhausted, in which case you will be transitioned to other ongoing care.

c. A reasonable transition period is determined on a case-by-case basis, during which time you would continue to see the non-plan provider. The decision as to how long this time will be takes into consideration the severity of your condition and the amount of time reasonably necessary to effect a safe transfer. This will be determined on a case-by-case basis with input from you and the therapist as to when it is safe to transition you to another provider, or into the full service health plan. The Medical Director will be consulted on these decisions.

The following conditions must be met to receive continuing care services from a licensed mental health provider who is not on Plan's panel:

a. Plan must authorize the continuing care.

b. Requested treatment must be a covered benefit under Group's EAP Services Agreement with Plan.

c. The non-plan provider must agree in writing to the same contractual terms as a plan provider, which includes payment rates.

d. Member must be new to Plan.

B. Terminated EAP Providers

Should Plan terminate an EAP Provider for reasons other than a disciplinary cause, fraud, or other criminal activity, you may be able to continue receiving Benefits from the terminated provider following the termination, if the provider agrees in writing to continue to provide Benefits under the terms and conditions of his/her agreement with Plan. To inquire about continued care, you should contact the Member Services Department.

XVI. CONTINUATION OF GROUP COVERAGE

A. COBRA Continuation of Coverage

If Group is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, you may be entitled to continuation of Group coverage under that act (COBRA Coverage). You may qualify for COBRA Coverage if you lose Group coverage due to the occurrence of certain qualifying events. Such events include, but are not limited to:

- Termination or separation from employment for reasons other than gross misconduct.

- Reduction of work hours.
- Death of the Participant.
- Termination of eligibility of a spouse due to divorce or legal separation.
- Termination of eligibility of a dependent child.
- Covered dependent if Member becomes eligible for Medicare

COBRA Coverage extends up to thirty-six (36) months, depending upon your qualifying event. COBRA Coverage may be terminated on the occurrence of certain events, including you becoming eligible for coverage under Medicare. In addition, COBRA Coverage is not available to certain Members, including those Members who have certain other coverage at the time of the qualifying event. You may obtain complete information on COBRA qualifying events, COBRA Coverage termination circumstances, and ineligibility for COBRA Coverage from Group.

Group is responsible for providing you with notice of your right to receive COBRA Coverage. You must provide Group, or Group's COBRA administrator, with a written request for COBRA Coverage within sixty (60) days of eligibility for such coverage or receipt of notice of the qualifying event. Qualified Members must make payment of Periodic Fees within forty-five (45) days of such written request. Members whose continuation of coverage under COBRA will expire may be eligible for continuation of coverage under Cal-COBRA.

B. Cal-COBRA Continuation of Coverage

1) Eligibility for Cal-COBRA Continuation Coverage

If Group is subject to the California Continuing Benefits Replacement Act (Cal-COBRA), Members may be entitled to continuation of Group coverage under that act (Cal-COBRA Coverage). Group is subject to Cal-COBRA continuation coverage if it: a) employs 2 – 19 employees on at least 50% of its working days during the preceding calendar year; or if the employer was not in business during any part of the previous year and employed 2 – 19 eligible employees on at least 50% of its working days during the previous calendar quarter; b) is not subject to the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). If your employer is subject to Cal-COBRA, you and your dependants may qualify for Cal-COBRA if you would lose coverage due to one of the following Qualifying Events:

- Termination of employment or reduction in work hours for reasons other than gross misconduct.
- Death of Enrollee.
- Termination of eligibility of a spouse due to divorce or legal separation.
- Termination of eligibility of a dependent child.
- Covered dependant if Member is entitled to Medicare.
- Member whose COBRA coverage will expire.

Cal-COBRA Coverage extends for up to thirty-six (36) months from the Qualifying Event unless earlier terminated by the occurrence of certain events.

Group is responsible for providing you with notice of your right to receive Cal-COBRA Coverage. You must provide Group, or Group's COBRA administrator, with a written request for Cal-COBRA Coverage within sixty (60) days of eligibility for such coverage or receipt of notice of the Qualifying Event. Qualified Members must make payment of Periodic Fees within forty-five (45) days of such written request.

2) Notification of Qualifying Events

It is the responsibility of the Member to notify Group of the occurrence of any of the Qualifying Events noted below within sixty (60) days:

- Subscriber's death.
- Spouse ceases to be eligible due to divorce or legal separation.
- Loss of dependent status by a Dependent enrolled in the group benefit plan.
- With respect to a covered Dependent only, the Subscriber's entitlement to Medicare.

Group must notify Plan within thirty (30) days of a termination of employment or reduction in work hours, which would result in ending coverage under the Member's group benefit plan. Failure to notify Plan within sixty (60) days of the occurrence of a Qualifying Event will disqualify the Member from receiving continuation coverage. Notifications of a Qualifying Event are generally made to Group, or Group's COBRA administrator.

3) Cal-COBRA Enrollment and Premium Information

Within fourteen (14) days of receiving notification of a Qualifying Event, Group, or Group's COBRA administrator, will send enrollment and premium information, including a Cal-COBRA Election Form. You must return the completed Cal-COBRA Election Form within the required time period. The Cal-COBRA Election Form must be received within sixty (60) days of the latest of these occurrences:

- The date coverage under the plan was terminated or will terminate due to a Qualifying Event; or
- The date you were sent the Cal-COBRA enrollment and premium information.

Your Cal-COBRA premium payment must be received within forty-five 45 days of the date that your Cal-COBRA Election Form was received. Failure to send the correct premium amount within forty-five (45) days will disqualify you from continuation coverage under Cal-COBRA. The first premium payment equals the amount of all premiums due from the first month following the Qualifying Event through the current month. After the initial payment, Cal-COBRA premiums are due

on the first day of each month. The Cal-COBRA premium is generally 110% of the premium charged to Group for employees. Your enrollment in Cal-COBRA will not occur until both your Cal-COBRA Election Form and your first Cal COBRA premium payment have been received.

4) Termination of Cal-COBRA Continuation Coverage

Usually, a Member's Cal-COBRA continuation coverage will last up to thirty-six (36) months. The continuation coverage shall end automatically if the individual becomes eligible for Medicare or becomes covered under any group health plan not maintained by the employer or any other health plan, regardless of whether that coverage is less valuable. Member's Cal-COBRA continuation coverage may terminate early if: Member moves out of Plan's service area; Member does not pay the required premium within fifteen (15) days of it being due; Member commits fraud or deception in using Plan's services; Member obtains other group coverage.

If the group benefit plan is terminated prior to the date that a Member's Cal-COBRA continuation coverage would expire, Member's coverage with Plan will expire. Member has the opportunity to continue coverage under the any group benefit plan purchased by Group. If Group purchases a new plan, that plan will send Member premium information and enrollment forms. Member may continue coverage for the remainder of the Cal-COBRA continuation period. It is important for Member to keep Plan and Group updated if there are any changes of address. Cal-COBRA continuation coverage will terminate if Member fails to enroll and pay premiums to the new group benefit plan within thirty (30) days after receiving notification of the termination of Plan's group benefit plan.

If Group changes its EAP benefit to another plan, Member's coverage with Plan will expire, and Member will be given the opportunity to continue coverage with the new plan. The new plan is required to provide coverage for the balance of the Cal-COBRA continuation coverage period.

XVII. COMPLAINT AND GRIEVANCE PROCEDURE

A grievance is a written or oral expression of dissatisfaction regarding Plan and/or an EAP Provider, including quality of care concerns, and includes a complaint, dispute, request for reconsideration, or appeal made by you or your representative. A complaint is the same as a grievance.

You are entitled to present complaints and grievances within one year of the occurrence. Plan is obliged to seek to resolve such complaints and grievances in a timely fashion. Plan has established a procedure for processing and resolving your complaints and grievances.

Should you desire to register a complaint or grievance with Plan concerning Benefits, you can either call Plan at the toll-free telephone number **1-800-342-8111**, or access Plan's website at **www.mylifevalues.com** to either download the complaint form or to fill it out

online. To request a copy of Plan's complaint form, write directly to Plan at 10260 Meanley Drive, San Diego, CA 92131. The telephone call or letter should be addressed to the Director, Clinical Quality Improvement. Plan will acknowledge each complaint and grievance within five (5) days of receipt. The Director, Clinical Quality Improvement will receive and investigate all Member complaints and grievances. The Director, Clinical Quality Improvement will respond to you stating the disposition and the rationale within thirty (30) days of receipt of the grievance. If the grievance is not resolved to your satisfaction, a second level of review may be requested within ten (10) days of notification of such disposition. Any such request will be reviewed by the Medical Director and responded to within seventy-two (72) hours of receipt.

Linguistic and cultural needs will be addressed by translation of grievance forms and procedures into languages other than English. Using TTY lines and varying the means by which an Enrollee may submit a grievance, including verbally to Plan's staff (bi-lingual capability), on website (Spanish and English), verbally by provider (multi-language capability), or interpreter. This allows Enrollees to submit grievances in a linguistically appropriate manner. When an Enrollee is seen with the aid of an interpreter, the interpreter or counselor reading this statement will explain the information that is normally provided in a written format.

If you have a complaint or grievance about the services you have received, or will receive in the future, you may notify your counselor (or interpreter), who will supply them with a grievance form and a description of the process. If you wish to submit the grievance through your counselor or interpreter, you may do so.

Visually impaired clients may phone the Director of Quality Improvement directly **at 1-800-342-8111**. The Director, Quality Improvement, will describe the grievance procedure and take the grievance information. In this case, the appropriate letters would be sent, and the client contacted by telephone so that the letter can be read. Hearing impaired clients may file a grievance using the telephone number **858-712-1080** to contact Plan.

If the complaint or grievance involves a delay, modification, or denial of service related to a clinically emergent or urgent situation, the review will be expedited and a response provided in writing to you within three (3) days from receipt of the complaint or grievance. There is no requirement that you participate in Plan's grievance process before requesting a review by the California Department of Managed Care (Department) in the case of an urgent or emergent grievance. The criteria for determining emergent situations are whether you are assessed to be at imminent risk to seriously harm yourself or another person, or are so impaired in judgment as to destroy property or be unable to care for your own basic needs. The criteria for determining urgent situations are whether you are assessed to be significantly distressed, and are in any medical danger due to the level of the problem, or are experiencing a reduced level of functioning due to more than a moderate impairment resulting in an inability to function in key family/work roles.

You, or the agent acting on your behalf, may also request voluntary mediation with Plan prior to exercising the right to submit a grievance to the Department. The use of mediation

services will not preclude your right to submit a grievance to the Department upon completion of the mediation. In order to initiate mediation, you, or the agent acting on your behalf, and Plan will voluntarily agree to mediation. Expenses for the mediation will be borne equally by the parties. The Department will have no administrative or enforcement responsibilities in connection with the voluntary mediation process. Mediations will take place in San Diego, California unless otherwise determined by the parties.

Pursuant to Section 1365(b) of the Act, any Member who alleges his enrollment has been canceled or not renewed because of his health status or requirement for services may request review by the Department.

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 Plan at **(1-800-342-8111)** and use Plan's grievance process (or locate Plan's grievance form on their website at **www.mylifevalues.com**) 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 plan, or a grievance that has remained unresolved for more than thirty (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-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online. Plan's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

XVIII. MISCELLANEOUS

A. Confidentiality Policy

A STATEMENT DESCRIBING PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO A MEMBER UPON REQUEST.

B. Member Consent

Under the EAP Services Agreement, Group makes Benefits which are consistent with professionally recognized standards of practice, available to Members. The EAP Services Agreement is subject to amendment, modification or termination, in accordance with the provisions thereof, or by mutual agreement between Plan and Group, without the consent or concurrence of Members. By accepting Benefits hereunder, all Members

legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions of the EAP Services Agreement.

C. Plan's Policies

Plan may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration of the EAP Services Agreement.

D. Plan's Public Policy Committee

Plan has established a Public Policy Committee that includes, among others, Members of Groups that have contracted with Plan for Benefits. This committee meets quarterly and Plan's Board of Directors reviews the reports and recommendations of the committee. Any Member desiring more information about this committee should contact Plan at 1-800-342-8111.

E. Term and Renewal Provisions

The initial term of the EAP Services Agreement is thirty-six (36) months. Thereafter the agreement is automatically renewed for successive twelve (12) month periods, subject to the termination provisions contained therein.

F. Important Information about Organ and Tissue Donations

Organ and tissue transplants have helped thousands of people with a variety of problems. The need for donated organs, corneas, skin, bone and tissue continues to grow beyond the supply. Organ and tissue donation provides you with an opportunity to help others. Almost anyone can become a donor. There is no age limit. If you have questions or concerns you may wish to discuss them with your doctor, your family, or your clergy.

Resources for Information:

- For information and donor card call 1-800-355-SHARE.
- Request donor information from the Department of Motor Vehicles.
- On the Internet, contact All About Transplantation and Donation (www.transweb.org).
- Department of Health and Human Services, contact http://www.organdonor.gov.

Share your decision with family.

If you decide to become a donor:

- Sign the donor card in the presence of family members.
- Have your family sign as witnesses and pledge to carry out your wishes.

EXHIBIT A

SCHEDULE OF BENEFITS, LIMITATIONS, AND EXCLUSIONS

Employee Assistance Program

A. Benefits.

1) Individual, couple, or family assessment and brief counseling for personal, marital, family, relationship, work-related, and alcohol or substance abuse problems. Brief counseling is provided when, in the judgment of the EAP provider, the issues meet community standards of practice for brief counseling within eight (8) private counseling sessions per separate incident. A "session" is defined as either an in-person or telephone consultation with the Member, of approximately one hour in duration. Sessions are used to identify or work on resolving the issues or conditions that the Member is experiencing. A new incident for the same Member would involve different issues or conditions. Benefits will be consistent with professionally recognized standards of practice. A separate incident involves a single underlying issue or condition, regardless of the number of same or different events involving the issue or condition. Plan shall make the clinical determination as to what constitutes a separate incident.
2) Referrals are offered to Members whose problem cannot be resolved within the scope of the eight (8) sessions per separate incident. The EAP Provider works with the Member to identify resources of an appropriate type and level of care beyond the benefit.
3) Referrals to other resources are offered to Members if the type of care is outside of the scope of practice of this benefit.
4) 24-hour crisis hotline, 7 days/week.
5) Referrals for legal consultation.
6) Referrals for financial counseling.
7) Identity theft consultation.

B. Limitations

1) The Benefits provided to Members by Plan are limited in nature as described in sections 1-7 above.
2) Plan will make a good faith effort to provide or arrange for the provision of Benefits to Members, in the event of certain circumstances, such as major disaster, epidemic, riot or civil insurrection.

C. Exclusions.

1) Inpatient treatment of any kind, or outpatient treatment for any medically treated illness.

2) Psychiatrist services.
3) Prescription drugs.
4) Counseling services beyond the number of sessions covered by the benefit.
5) Services by counselors who are not Participating Providers.
6) Court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, custody, or visitation evaluations, or paid for by Workers' Compensation.
7) Formal psychological evaluations which normally involve psychological testing and result in a written report.
8) Fitness for duty evaluations which are used to evaluate whether an employee is safely able to perform his or her duties. This typically includes psychological testing and a written report.
9) Investment advice (nor does Plan loan money or pay bills).
10) Legal representation in court, preparation of legal documents, or advice in the areas of taxes, patents, or immigration.

EXHIBIT B

COMPARISON OF BENEFITS

The Employee Assistance Program (EAP) is being offered by your employer to provide you with confidential assistance from licensed mental health professionals. These professionals can help with problems affecting your life at work as well as at home. Such problems include marital issues, family relationships, depression and anxiety, alcohol and drug issues, and/or problems within the workplace.

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM AND THE EAP SERVICES AGREEMENT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF BENEFITS, LIMITATIONS AND EXCLUSIONS.

A. Deductible	Not applicable
B. Lifetime Maximum	Not applicable
C. Professional Services	The EAP provides: Psychosocial Assessment Treatment Referrals and Resources for Psychosocial Problems 24-hour Crisis Telephone Access Eight (8) Counseling Sessions Per Incident Legal Referrals Financial Counseling Referrals Identity Theft Consultation
D. Outpatient Services	Please see Item C: Professional Services
E. Hospitalization Services	None
F. Emergency Health Coverage	Please see Item C: Professional Services
G. Ambulance Services	None
H. Prescription Drug Coverage	None
I. Durable Medical Services	None
J. Mental Health Services	Please see Item C: Professional Services
K Chemical Dependency Services	Please see Item C: Professional Services
L. Home Health Services	None
M. Other	None

Members pay no co-payment. Coverage is limited to: a) eligible employees; b) the eligible employee's children under the age of 26; c) persons covered under the eligible employee's health benefit plan; d) persons residing with the eligible employee, including domestic partners of the same or opposite sex.