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, 2016

Human Resources Department
City of Chula Vista

BARNEY&BARNEY
A Marsh & McLennan Agency LLC Company

August 18, 2014 **TRANSMITTED VIA E-MAIL**

Gig Kaney
Senior Account Executive
Aetna Resources for Living

RE: City of Chula Vista – 1/1/2015 Renewal Confirmation, Group #0643

Dear Gigi:

The purpose of this letter is to confirm that the City of Chula Vista will be renewing their Employee Assistance Plan with Aetna Resources for Living, effective January 1, 2015, with the following rates & conditions.

I. MONTHLY PREMIUM RATES EFFECTIVE JANUARY 1, 2015 – DECEMBER 31, 2017

Final monthly premium rates for **Active Employees/Early Retirees** are:

Aetna Employee Assistance Plan 8 EAP Sessions per incident 6 hours training included	2012 through 2014	2015 through 2017	% Change
PER EMPLOYEE PER MONTH	$1.79	**$1.79**	0%

II. RATE GUARANTEE

Rates are guaranteed for a period of 36 months, January 1, 2015 through December 31, 2017.

III. ON-SITE SERVICES:

a. **Critical Incident Stress Debriefings (CISD)/ Grief Groups:**
   i. Standard Service (on-site attendance response time is greater than two hours): $250 per hour plus travel and prep fee at a flat rate of $150 per location;
   ii. Immediate Service (on-site attendance response time is less than two hours): $350 per hour plus travel and prep fee at a flat rate of $150 per location
b. **Reduction In Force:** $250 per hour plus travel and prep fee at a flat rate of $150 per location
c. **Trainings:** 6 free hours. For web-based trainings with more than 25 participants, an additional charge of $50.00 applies for each additional 25 participants up to a maximum of 200 participants.
   i. After 6 free training hours, on-site trainings: $250 per hour plus $150 per location for travel and prep.
   ii. Webinar trainings: $250 per hour plus $150 for prep. 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.
d. **Orientations**: Employee or Supervisor orientations included at No Charge.
e. **DOT/SAP Consultation and Assessment Services:** Included at No Charge per case.
   i. DOT Supervisor Training - 2 hours at $800
   ii. DOT Employee Training - 1 hour at $400

iii. Fees for DOT Employee and Supervisor training will be assessed on a case-by-case basis and are dependent upon travel expenses and for classes that exceed 50 participants.

IV. NO BENEFIT PLAN DESIGN CHANGES WILL BE EFFECTIVE JANUARY 1, 2015

V. CONFIRMATION STATEMENT
I acknowledge the above is true and accurate.

Gigi Kaney *8/20/14*

_____ _____

Gigi Kaney, Sr. Account Executive **Date**
Aetna Resources for Living

Sincerely,
Megan Baldwin
Client Manager
Barney & Barney, a Marsh & McLennan Agency LLC Company

cc: City of Chula Vista

HEALTH AND HUMAN RESOURCE CENTER, INC.
(dba HORIZON HEALTH EAP-BEHAVIORAL SERVICES)
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 Horizon Health EAP-Behavioral Services ("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 Horizon Health EAP-Behavioral Services.

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 written notice at least ninety (90) days prior to the expiration of the Initial Term or the current Renewal Term. 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 Horizon Health EAP-Behavioral Services 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 the Plan against a Member for filing a grievance.

Members are entitled to present complaints and grievances. Horizon Health EAP-Behavioral Services 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. Horizon Health EAP-Behavioral Services has established a procedure for processing and resolving Member complaints and grievances.

Should a Member desire to register a complaint or grievance with Horizon Health EAP-Behavioral Services concerning Benefits, he/she can either call Horizon Health EAP-Behavioral Services at the toll-free telephone number 1-800-342-8111 to report the complaint or grievance, or to request a copy of the Horizon Health EAP-Behavioral Services Complaint Form, or write directly to Horizon Health EAP-Behavioral Services at 7676 Hazard Center Drive, Suite 1100, San Diego, CA 92108. The telephone call or letter should be addressed to the Director, Clinical Quality Improvement. Horizon Health EAP-Behavioral Services 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 Horizon Health EAP-Behavioral Services' 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 Horizon Health EAP-Behavioral Services 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 Horizon Health EAP-Behavioral Services 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 the Plan, the member should first telephone the Plan at **(1-800-342-8111)** and use the Plan's grievance process (or locate their grievance form on Horizon Health EAP-Behavioral Services' website at **www.horizoncarelink.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 the 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. The 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. 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.

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

J. 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.

K. 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.

L. 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.

M. 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.

N. 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.

O. 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.

P. 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.

EXHIBIT A
Schedule of Benefits

Employee Assistance Program

A. Benefits.

1. Individual and family assessment and counseling for personal, marital, family, relationship, work-related, alcohol and substance abuse problems that in the judgment of the EAP Provider meet community standards of practice for such counseling and can be satisfactorily resolved in no more than eight (8) private counseling sessions per separate incident, within a twelve month period under the Agreement. A "session" is defined as either an in person or telephone consultation with the Member, of approximately one hour in duration, in connection with the Member's problems, to identify and evaluate such problems. 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 by EAP Providers to licensed and accredited mental health agencies, practitioners and programs, for any Member whose problem, in the judgment of an EAP Provider, is of a type and level of severity to require a professional diagnostic evaluation and/or consideration of medical intervention on an emergency or non-emergency basis.
3. Referrals to non-medical agencies, practitioners and programs for a Member whose problem, following an assessment rendered by an EAP Provider, is not of a type or level of severity to meet community standards of practice for further counseling Benefits.
4. 24-hour crisis hotline, 7 days/week.
5. Referrals for legal consultation.
6. Referrals for financial counseling.
7. Identity theft consultation.
8. Childcare/Eldercare database on Horizon Health website.

B. Services.

1. Management consultations.
2. Promotional and educational materials.
3. Drug-free workplace policy development assistance, consultation.
4. Participation at health/benefit fairs as agreed upon.
5. Statistical data relating to the use of the EAP.
6. Employee Orientation Meetings. Plan will make available on-site meetings for eligible employees to acquaint eligible employees with the operation of the EAP and to encourage eligible employees to use the EAP.
7. Supervisor Orientation and Training. Plan will make available training programs for Group's employees who provide supervision to others as part of their day-to-day duties. The purpose of this training program will be to acquaint supervisors with the operation of the EAP and to motivate supervisors to encourage Members to use the EAP.

8. Comprehensive Substance Abuse Professional (SAP) Services. 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, initial and follow up SAP evaluation, as well as case management throughout the SAP aftercare recommendations. Plan shall refer to a qualified SAP to conduct initial assessment and provide treatment recommendations, follow-up testing schedule, referral to treatment resource and compliance meeting, as defined by DOT SAP guidelines. After an Eligible Employee's return to the workplace, and upon request of Group, Plan shall provide ongoing case management through completion of aftercare recommendations. Per DOT Regulation, Group has final decision-making authority regarding the return of an Eligible Employee to the workplace. If a referral to a treatment resource occurs, Eligible Employee will be responsible for the cost of services provided by the treatment source.

9. Standard EAP Seminars and Trainings. Plan will provide a total of **six (6) hours** of Standard EAP Seminars and Trainings on such topics as stress management, weight loss, smoking, conflict resolution and substance abuse prevention.

   Additional Seminars and Trainings will be provided at the rate of **Two Hundred Seventy-Five Dollars ($275.00)** per hour/per clinician. Travel both to and from the Group's premises shall be paid at a rate of **Fifty Dollars ($50.00)** per hour of travel. Web-based seminars, in which participants view the presentation through their web browser and listen to the audio through their telephone, are available at the rate of **Two Hundred Dollars ($200.00)** per hour/per clinician. Cancellations within twenty-four (24) hours of requested service will be charged a **Two Hundred Seventy-Five Dollars ($275.00)** per onsite hour/per clinician administrative fee.

The following EAP Services are in addition to the per eligible employee/per month fee:

10. Critical Incident Stress Debriefing (CISD)/Critical Incident. Plan will make available to Group, upon its request, at Group's premises, an EAP Provider to provide group crisis counseling to Group's employees in the event of a catastrophic incident affecting a group of employees (e.g., robbery at the workplace, assault in the workplace, employee death in the workplace). Plan will schedule a CISD at the worksite with a group of employees directly impacted by a critical incident as soon as clinically necessary following the traumatic event. CISDs will be provided at the rate of **Three Hundred Twenty-Five Dollars ($325.00)** per on-site hour/per clinician. Travel both to and from the Group's premises shall be paid at a rate of **Fifty Dollars ($50.00)** per hour of travel. Cancellations within twenty-four (24) hours of requested service will be charged a **Three Hundred Twenty-Five Dollar ($325.00)** per on-site hour/per clinician administrative fee.

11. Reduction in Force. The process by which a work organization reduces its work force by eliminating jobs, such as closing subsidiaries or departments. On-site services for Reduction in Force will be provided at the rate of **Three Hundred Twenty-Five Dollars ($325.00)** per on-site hour/per clinician. Travel both to and from the Group's premises shall be paid at a rate of **Fifty Dollars ($50.00)** per hour of travel. Cancellations within twenty-four (24) hours of requested service will be charged a **Three Hundred Twenty-Five Dollar ($325.00)** per on-site hour/per clinician administrative fee.

12. Grief Groups. An on-site group that is facilitated by a provider to help employees deal with the death of a co-worker, family member, etc. Grief Groups will be provided at the rate of **Three Hundred Twenty-Five Dollars ($325.00)** per on-site hour/per clinician. Travel both to and from the Group's premises shall be paid at a rate of **Fifty Dollars ($50.00)** per hour of travel.

Cancellations within twenty-four (24) hours of requested service will be charged a **Three Hundred Twenty-Five Dollar ($325.00)** per on-site hour/per clinician administrative fee.

13. On-Site Counseling. An on-site counselor can be provided to assist with providing one-on-one counseling in a confidential on-site location. On-site counseling will be provided at the rate of **Three Hundred Twenty-Five Dollars ($325.00)** per on-site hour/per clinician. Travel both to and from the Group's premises shall be paid at a rate of **Fifty Dollars ($50.00)** per hour of travel. Cancellations within twenty-four (24) hours of requested service will be charged a **Three Hundred Twenty-Five Dollar ($325.00)** per on-site hour/per clinician administrative fee.

14. Awareness Trainings. Plan will provide Awareness Trainings on topics such as Department of Transportation (DOT) Drug/Alcohol Awareness, Diversity in the Workplace, Drug Free Workplace, and Sexual Harassment for Employees, and Violence in the Workplace. Awareness Trainings will be provided at the rate of **Three Hundred Fifty Dollars ($350.00)** per on-site hour/per clinician. Travel both to and from the Group's premises shall be paid at a rate of **Fifty Dollars ($50.00)** per hour of travel. Cancellations within twenty-four (24) hours of requested service will be charged a **Three Hundred Fifty Dollar ($350. 00)** per on-site hour/per clinician administrative fee.

The above quotes are valid only for the Initial Term. Pricing will be provided in advance of any Renewal Term. If no such pricing is provided, then the pricing above will remain in effect for such Renewal Term.

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.

HORIZON HEALTH EAP-BEHAVIORAL SERVICES
COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

TABLE OF CONTENTS

HEALTH AND HUMAN RESOURCE CENTER
(dba HORIZON HEALTH EAP-BEHAVIORAL SERVICES)
7676 Hazard Center Drive, Suite 1100
San Diego, CA 92108
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 Horizon Health EAP-Behavioral Services at 1-800-342-8111 to receive additional information about Benefits.

Enclosed as Exhibit B is Horizon Health EAP-Behavioral Services' matrix of covered services.

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, Horizon Health EAP-Behavioral Services to provide Benefits to Members.

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

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. "Group" means the company that has entered into an EAP Services Agreement with Horizon Health EAP-Behavioral Services for Horizon Health EAP-Behavioral Services to provide Benefits to Members.

G. "Plan" means Health and Human Resource Center, Inc., doing business as Horizon Health EAP-Behavioral Services.

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 the 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.

K. "Periodic Fees" means the monthly amounts due and payable to Horizon Health EAP-Behavioral Services by a 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;
- Serious dysfunction of any bodily organ or part; or
- Active labor, meaning labor at a time that either of the following would occur
    1) There is inadequate time to effect safe transfer to another hospital prior to delivery; or
    2) A transfer poses a threat to the health and safety of the Member or unborn child.

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, Horizon Health EAP-Behavioral Services will determine your eligibility for Benefits and arrange for Benefits.

All Benefits must be provided by Horizon Health EAP-Behavioral Services or by an EAP Provider referred to by Horizon Health EAP-Behavioral Services. 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.

Horizon Health EAP-Behavioral Services does not directly provide specialty services beyond assessment, brief counseling and/or referral. Horizon Health EAP-Behavioral Services' 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. The 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 Horizon Health EAP-Behavioral Services at 1-800-342-8111. Horizon Health EAP-Behavioral Services provides crisis intervention both during and after business hours at this number. A member who is currently outside the Plan service area and requires this service can call 1-800-342-8111. Members can obtain care if they are temporarily outside of the Plan 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

Horizon Health EAP-Behavioral Services bills the Group for Periodic Fees and the Group remits such fees to Horizon Health EAP-Behavioral Services each month during the term of the EAP Services Agreement for Members entitled to receive Benefits during such month. Horizon Health EAP-Behavioral Services may change the Periodic Fees and/or Benefits under the EAP Services Agreement, effective thirty (30) days after receipt by the Group of written notice from Horizon Health EAP-Behavioral Services 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

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

VII. PREPAYMENT OF FEES

The Member does not pay co-payments, deductibles, or fees for the Plan. All fees are paid by the 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 Horizon Health EAP-Behavioral Services 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 Horizon Health EAP-Behavioral Services 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 HORIZON HEALTH EAP-BEHAVIORAL SERVICES / MEMBERS

A. Liability of Horizon Health EAP-Behavioral Services

In the event Horizon Health EAP-Behavioral Services fails to pay EAP Providers for Benefits provided to you, you shall not be liable to EAP Providers for any sums owed by Horizon Health EAP-Behavioral Services.

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 the 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 Horizon Health EAP-Behavioral Services.

XI. PROVIDER COMPENSATION

Horizon Health EAP-Behavioral Services 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.

Horizon Health EAP-Behavioral Services 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 Horizon Health EAP-Behavioral Services' EAP Provider reimbursement policies and procedures by contacting Horizon Health EAP-Behavioral Services' 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. Horizon Health EAP-Behavioral Services 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. Horizon Health EAP-Behavioral Services 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 Horizon Health EAP-Behavioral Services 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 the Plan. If you request a second opinion from a provider not under contract with Horizon Health EAP-Behavioral Services, you must provide an explanation as to why an EAP Provider cannot render such an opinion. The Horizon Health EAP-Behavioral Services 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 7676 Hazard Center Drive, Suite 1100, San Diego, CA 92108. All requests for second opinions shall be processed and approved or denied by Horizon Health EAP-Behavioral Services 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 the 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. The Group shall be responsible for notifying Horizon Health EAP-Behavioral Services of any Enrollee who becomes newly eligible after the effective date of the EAP Services Agreement. Horizon Health EAP-Behavioral Services shall rely upon the determination by the 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 Horizon Health EAP-Behavioral Services to the Group, which shall then advise Horizon Health EAP-Behavioral Services of its determination with respect to the matter.

XIV. TERMINATION OF BENEFITS

Usually, your enrollment in the Plan terminates when the Group or Enrollee is no longer eligible for coverage under the employer's EAP Plan. In most instances, the 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 the Group Contract for Nonpayment of Premiums

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

The 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 your Group within 15 days of the date the Prospective Notice of Cancellation is mailed, the Plan will mail the Group a Notice Confirming Termination of Coverage, which the Group will then forward to you. This notice will provide you with the following information:

1) That the Group Contract has been cancelled for non-payment of premiums;

2) The specific date and time when your 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 the Group Agreement is cancelled for the Group's nonpayment of premiums, then the Plan will permit reinstatement of the Group Agreement if the Group pays the amounts owed within 15 days of the date of the Notice Confirming Termination is mailed to the Group.

C. Member Termination for Non-Eligibility

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

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

Ending Coverage – Special Circumstances for Enrolled Family Members.
Enrolled Family Members terminate on the same date of termination as the 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

The 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 the Plan, its Participating Providers (or knowingly allow another person to do the same). Termination is effective immediately on the date the Plan mails the Notice of Termination, unless the 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 the Plan, reinstatement with the Plan is subject to all terms and conditions of the EAP Services Agreement between the 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 the Horizon Health EAP-Behavioral Services 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 Horizon Health EAP-Behavioral Services 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 the Horizon Health EAP-Behavioral Services panel:

a. Horizon Health EAP-Behavioral Services must authorize the continuing care.

b. The requested treatment must be a covered benefit.

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

d. The Member must be new to Horizon Health EAP-Behavioral Services.

B. Terminated EAP Providers

Should Horizon Health EAP-Behavioral Services 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 Horizon Health EAP-Behavioral Services. To inquire about continued care, you should contact the Member Services Department.

XVI. CONTINUATION OF GROUP COVERAGE

A. COBRA Continuation of Coverage

If the 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 the Group.

The Group is responsible for providing you with notice of your right to receive COBRA Coverage. You must provide Horizon Health EAP-Behavioral Services, or the Group, 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 to the Group or COBRA administrator 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 a 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). A 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 the 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.

The Group is responsible for providing Members with notice of their right to receive Cal-COBRA Coverage. The Member must provide the Group or 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. Eligible Members must make payment of Periodic Fees to Horizon Health EAP-Behavioral Services within forty-five (45) days of such written request.

2) Notification of Qualifying Events

It is the responsibility of the Member to notify Horizon Health EAP-Behavioral Services of the occurrence of any of the Qualifying Events noted below within sixty (60) days. The Qualifying Events that the Member is responsible for notifying include:

- 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.

The Group must notify Horizon Health EAP-Behavioral Services 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 Horizon Health EAP-Behavioral Services 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 the Group or the Group's COBRA Administrator. If the Member has questions, he/she may contact the Group, or Horizon Health EAP-Behavioral Services at 1-800-342-8111.

3) Cal-COBRA Enrollment and Premium Information

Within fourteen (14) days of receiving notification of a Qualifying Event, Horizon Health EAP-Behavioral Services will send enrollment and premium information, including a Cal-COBRA Election Form. The Member 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 the Member was sent the Cal-COBRA enrollment and premium information.

Horizon Health EAP-Behavioral Services must receive the first Cal-COBRA premium payment within forty-five 45 days of the date the Member's Cal-COBRA Election Form was received. Failure to send the correct premium amount with forty-five (45) days will disqualify the Member 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 the Group for employees. The Member's enrollment in Cal-COBRA will not occur until Horizon Health EAP-Behavioral Services receives both the Cal-COBRA Election Form and the first Cal COBRA premium payment.

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. The Member's Cal-COBRA continuation coverage may terminate early if the Member moves out of Horizon Health EAP-Behavioral Services' service area, does not pay the required premium within fifteen (15) days of it being due, or commits fraud or deception in using Horizon Health EAP-Behavioral Services' services, or obtains other group coverage.

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

If the group changes its EAP benefit to another plan, the Members coverage with Horizon Health EAP-Behavioral Services will expire, and you 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 Horizon Health EAP-Behavioral Services 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. Horizon Health EAP-Behavioral Services is obliged to seek to resolve such complaints and grievances in a timely fashion. Horizon Health EAP-Behavioral Services has established a procedure for processing and resolving your complaints and grievances.

Should you desire to register a complaint or grievance with Horizon Health EAP-Behavioral Services concerning Benefits, you can either call Horizon Health EAP-Behavioral Services at the toll-free telephone number **1-800-342-8111**, or access the website at **www.horizoncarelink.com** to either download the complaint form or to fill it out online. To request a copy of the Horizon Health EAP-Behavioral Services Complaint Form, write directly to Horizon Health EAP-Behavioral Services at 7676 Hazard Center Drive, Suite 1100, San Diego, CA 92108. The telephone call or letter should be addressed to the Director, Clinical Quality Improvement. Horizon Health EAP-Behavioral Services 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 Horizon Health EAP-Behavioral Services' 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 you are 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 of 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 Horizon Health EAP-Behavioral Services.

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 Horizon Health EAP-Behavioral Services' 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 Horizon Health EAP-Behavioral Services 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 Horizon Health EAP-Behavioral Services 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 your plan at **(1-800-342-8111)** and use the plan's grievance process (or locate their grievance form on Horizon Health EAP-Behavioral Services' website at **www.horizoncarelink.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. The 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 HORIZON HEALTH EAP-BEHAVIORAL SERVICES' 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, the 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 Horizon Health EAP-Behavioral Services and the 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. Horizon Health EAP-Behavioral Services' Policies

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

D. Horizon Health EAP-Behavioral Services' Public Policy Committee

Horizon Health EAP-Behavioral Services has established a Public Policy Committee that includes, among others, Members of Groups that have contracted with Horizon Health EAP-Behavioral Services for Benefits. This committee meets quarterly and the Horizon Health EAP-Behavioral Services Board of Directors reviews the reports and recommendations of the committee. Any Member desiring more information about this committee should contact Horizon Health EAP-Behavioral Services 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

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. The 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.
8) Childcare/Eldercare database on Horizon Health website.

B. Limitations

1) The Benefits provided to Members by Horizon Health EAP-Behavioral Services are limited in nature as described in sections 1-8 above.
2) Horizon Health EAP-Behavioral Services 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 Horizon Health EAP-Behavioral Services 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

HEALTH AND HUMAN RESOURCE CENTER
(dba HORIZON HEALTH EAP-BEHAVIORAL SERVICES)

EMPLOYEE ASSISTANCE PROGRAM

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.