

**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. “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.
- L. “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.
- M. “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. PREPAYMENT OF FEES

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

VI. 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.

VII. 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.

VIII. 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.

IX. PROVIDER COMPENSATION

Members may request 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.

X. 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.

XI. 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.

XII. 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).

Ending Coverage – Special Circumstances for Enrolled Family Members.

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.

XIII. 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.

XIV. 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 dependents 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 dependent 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 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.

XV. 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.resourcesforliving.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 your health plan at **(1-800-342-8111)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-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 you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

XVI. 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

I 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 ten (10) 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 ten (10) 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.

II. Telephonic WorkLife Program Services

A. Benefits

Our exclusive, phone-based program designed to assist members with a full range of WorkLife issues. Members are connected with WorkLife specialists who can assist them with child and elder care issues, temporary care, special needs, disaster relief, personal and convenience services, and many other needs.

B. Limited Liability

Plan makes no warranties, expressed or implied, with respect to any information, service or product provided by a WorkLife referral or on-line assessment provided to Members ("Referees") and all such warranties are expressly disclaimed by Plan and waived by Group. Referrals to "Referees" do not imply an endorsement, recommendation, or approval by Plan of the particular information, service, or product provided to the Referee. While Plan makes every effort to make appropriate referrals for Members, Plan does not guarantee the accuracy of the information, or the quality or appropriateness of the services

or products provided to the Referee. The decision about any information, products, or services to a Referee must be made by the Members themselves or Group, as applicable.

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 Ten (10) 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.