

Combined Evidence of Coverage and Disclosure Form

To request an additional Evidence of Coverage (“EOC”), please contact the Plan at:

TELUS Health (California) Ltd.
27715 Jefferson Avenue, Suite 103
Temecula, CA 92590

1-800-234-5154

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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 EAP 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 ("EOC") is 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 provided on request and is available from your employer.

This EOC 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 EOC in a safe place where you can easily refer to it when you need Benefits.

Contact Plan at **1-800-234-5154** or your employer's dedicated line to receive additional information about Benefits. Enclosed as Exhibit B is Plan's Comparison of Benefits.

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 **1-800-234-5154** or your employer's dedicated line.

IMPORTANTE: ¿Puede leer este documento? En caso de no poder leerlo, le brindamos nuestra ayuda. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al **1-800-234-5154** o al numero correspondiente de su empleador.

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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., and Title 28, California Code of Regulations).

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

C. "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 **1-800-234-5154**.

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

E. "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 Enrollees by Plan.

F. "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 Enrollee to result in any of the following:

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

G. "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.

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H. "Enrollee" means any eligible employee of Group who (1) resides in California and (2) may be covered under the Act. For purposes of this document, this definition shall include 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.

I. "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.

J. "Grievance" means a written or oral expression of dissatisfaction to the plan or the Director of the Department of Managed Health Care regarding the Plan and/or a Provider, including a written or oral expression of dissatisfaction by an Enrollee or Group who believes their plan contract, enrollment or subscription has been or will be improperly cancelled, rescinded or not renewed, quality of care concerns, and shall include a complaint, dispute, and request for reconsideration or appeal made by a Enrollee or the Enrollee's representative. Where the Plan is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

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

L. "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.

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

N. "Plan" means TELUS Health (California) Ltd.

O. "Qualifying Event" means any event that will cause an Enrollee or Enrollee's dependent to lose Group coverage.

II. HOW TO OBTAIN BENEFITS

Enrollees obtain Benefits by calling **1-800-234-5154**, or their employer's dedicated line. Client Care Representatives are the first point of contact for Enrollees and are responsible

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for identifying an Enrollees needs and recommending the most appropriate support. Upon contact, TELUS Health (California) Ltd. determines Enrollee eligibility for Benefits.

TELUS Health (California) Ltd. does not directly provide specialty services beyond assessment, brief counseling and/or referral. TELUS Health role in the referral process is to ensure that Enrollees obtain necessary and appropriate levels of care.

TELUS Health (California) Ltd. will make every effort to refer an Enrollee to a contracted provider that is a match for the presenting concerns of the Enrollee. TELUS Health (California) Ltd. also recognizes that there may be circumstances in which a contracted provider may not be within a reasonable distance and the Enrollee may not be appropriate for video-based services, in which case Enrollee will be referred to an out-of-network provider. TELUS Health (California) Ltd. will authorize out-of-network services at the in-network cost, where a closer, non-contracted provider is available and the service is covered. In such a circumstance, a temp request will be submitted.

A temp request will be submitted for the following reasons:

- There are no contracted providers within a 25-mile radius of the Enrollee's preferred locations;
- The contracted provider is not accepting new patients;
- Enrollee is not appropriate candidate for telehealth; or
- Enrollee declines telehealth.

Video counseling should be offered to the Enrollee, if clinically appropriate, prior to submitting a temp request.

A temp request will not be submitted based on:

- Age
- Ethnicity
- Religious preference
- A contracted providers is available within 25-mile radius.
- Based on a language necessity or hearing impairment. Enrollee should be offered the language line option before submitting a temp request

During or after business hours, any Enrollee may access a Client Care Representative for a telephone assessment. The Client Care Representative may arrange a same-day appointment with an EAP Provider in Enrollee's area, or assist Enrollee in obtaining more intensive, acute care services.

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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.

A. 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 Services.

Plan will maintain a 24 hours per day, 7 days week telephone access line, at **1-800-234-5154**, for calls from Enrollees, including Crisis Intervention or Emergency Services.

IV. CRISIS INTERVENTION

If you need Crisis Intervention or problem solving, call Plan at **1-800-234-5154** or your employer's dedicated line. Plan provides Crisis Intervention both during and after business hours at this number. An Enrollee who is currently outside Plan's service area and requires this service can call the same number as indicated above. Enrollees can obtain care if they are temporarily outside of Plan's service area. Enrollees can also be scheduled for an appointment on an urgent basis following assessment by a licensed clinician over the telephone.

V. PERIODIC FEES

Plan bills Group for Periodic Fees and Group remits such fees to Plan during the term of the EAP Services Agreement for Enrollees entitled to receive Benefits. Plan may change the Periodic Fees and/or Benefits under the EAP Services Agreement, effective 90 days after receipt by Group of written notice from Plan setting forth any such change. There are no co-payments, deductibles, or charges to you for Benefits.

VI. OTHER CHARGES

Plan will bill Group for additional services or Benefits provided under the Agreement. Group will remit payment to Plan within thirty (30) days of receipt of invoice. The Enrollee has no payment obligations to the Plan. All fees are paid by Group.

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VII. PREPAYMENT FEES

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

VIII. CHOICE OF EAP PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS BENEFITS MAY BE OBTAINED: You will be referred to an EAP Provider in accordance with your clinical, appointment time, and location needs. You should call Plan at **1-800-234-5154**, or your employer's dedicated line, to determine the names and locations of EAP Providers.

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

IX. TELEHEALTH

You can obtain Covered Services in-person or via telehealth from an EAP Provider. Telehealth services are covered on the same basis and to the same extent that as the same in-person Covered Service.

Regardless of how you receive Covered Services, all fees are paid by the Group. There is no difference in the cost to your Group, and no difference in how Providers are paid. Both in-person and telehealth services will be assessed towards your available Benefits.

If you are currently receiving telehealth services from an EAP Provider, you have the option of continuing to receive that service with that EAP Provider as long as the EAP Provider remains contracted with TELUS Health.

X. FACILITIES

The location of EAP Providers is obtained by calling Plan at **1-800-234-5154** or your employer's dedicated line. If you prefer, a customized list of EAP Providers will be provided upon request. This is arranged by zip code in the area specialty that you request.

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XI. LIABILITY OF PLAN / ENROLLEES

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. If an Enrollee receives a bill from the EAP Provider, they should contact the Plan to resolve the issue at **1-800-234-5154**.

B. Liability of Enrollees

It is not contemplated that Enrollees would make payment to EAP Providers for Benefits. If this has occurred, the Enrollee may contact Plan at **1-800-234-5154** to be reimbursed.

C. Enrollee 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.

XII. PROVIDER COMPENSATION

Plan compensates EAP Providers through an agreement by which they are paid a fixed amount of money based on hours worked, number of Enrollees seen, or number of sessions provided. EAP Providers are compensated within thirty (30) days after claim is received. EAP Providers are reimbursed for telehealth services on the same basis and to the same extent that the Plan is responsible for reimbursement for the same Covered Service through in-person diagnosis, consultation, and treatment.

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

A. Filing Claims

It is not contemplated that Enrollees would make payment to Plan EAP Providers for Benefits. If this has occurred, the Enrollee may contact Plan at **1-800-234-5154** to be reimbursed. There is no restriction on assignment of sums payable to the Enrollee by the health plan. Enrollees must file their claim within 180 days of service.

Enrollees may request further information about Plan's EAP Provider reimbursement policies and procedures by contacting Plan's Clinical Director at **1-800-234-5154** or the Enrollee's EAP Provider.

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For an Enrollee to be reimbursed, the Enrollee must include the itemized statement of services, the Enrollee's name, address, Enrollee ID number, dates of Services, treating EAP Provider's name, address, and telephone number, and a statement of the problem, and mail it to:

TELUS Health (California) Ltd.
27715 Jefferson Ave., #103
Temecula, CA 92590

The Enrollee should retain a copy of the information, and the Plan will either send the Enrollee a check or explain any denial within thirty (30) days of the Plan's receipt of the Enrollee's claim.

XIII. 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 non-EAP Provider not under contract with Plan, you must provide an explanation as to why an EAP Provider cannot render such an opinion. Plan's Clinical 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 Clinical Director at **1-800-234-5154** or in writing to TELUS Health (California) Ltd. 27715 Jefferson Ave, #103, Temecula CA 92590. 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.

XIV. 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

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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.

XV. TERMINATION OF BENEFITS

Usually, your enrollment in the plan terminates when Group or Enrollee is no longer eligible for coverage under the Group'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

Your enrollment shall not be canceled or not renewed except for specific reasons permitted by the Act and Rules, including but not limited to the following (and subject to additional requirements):

1) For nonpayment of required Premiums (by Group),

2) Fraud or intentional misrepresentation of material fact under the terms of the EAP Services Agreement,

3) The Enrollee no longer resides, lives, or works in the Plan's service area,

4) Violation of a material contract provision relating to employer contribution or Group participation rates by the Group,

5) If the Plan ceases to provide or arrange for the provision of Benefits for new health care service plan contracts, or

6) If the Plan withdraws from the market.

An Enrollee or Group who believe a plan contract, enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed shall have at least 180 days from the date of the notice that the Enrollee, subscriber, or group contract holder alleges to be improper to submit a Grievance to the plan, and may also submit a Grievance to the

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Director of the Department of Managed Health Care ("DMHC"). If the Director determines that the cancellation, rescission, or failure to renew is contrary to existing law, the Director shall order the Plan to reinstate the Enrollee or Group.

Pursuant to Section 1365(b) of the Act, any Enrollee 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 of Managed Health Care.

B. Cancellation, Rescission, or Nonrenewal for Nonpayment

Groups subject to cancellation and nonrenewal for nonpayment of Premiums will be sent a Notice of Start of Grace Period. The Group is entitled to a grace period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated, prior to cancellation, as follows:

1) The grace period may not begin sooner than the day after the last date of paid coverage.

2) The Plan shall provide coverage pursuant to the terms of the contract during the entire grace period.

3) Upon determining that a Group has failed to make a Premium payment by the due date, the plan shall send a Notice of Start of Grace Period to the Group notifying the recipient that a payment delinquency has triggered a grace period starting from the day the Notice of Start of Grace Period is dated.

4) The Plan shall continue the Enrollee's coverage uninterrupted pursuant to the plan contract upon payment of all outstanding Premium amounts at any time before the expiration of the grace period.

5) The Group is financially responsible for any and all premiums obligated under the EAP Services Agreement, including those incurred for services received during the grace period.

6) In the event the Plan, after compliance with all timing and notice requirements of this section, fails to receive all outstanding premium amounts from the Group on or before the last day of the grace period, as specified in the Notice of Start of Grace Period, coverage may be

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cancelled prospectively only after the expiration of the entire grace period.

7) The Plan shall send a Notice of End of Coverage for all cancellations to the Group after the date of coverage ended, and no later than five (5) calendar days after the date coverage ended.

8) The Plan shall send the Notice of Start of Grace Period and the Notice of End of Coverage to the Group. The Group shall promptly send a legible, true copy of the notice to its Enrollees and to provide the Plan with proof of such mailing and the date thereof.

C. Cancellation, Rescission, or Nonrenewal for Reasons Other than Nonpayment

For all cancellations for reasons other than for nonpayment of premiums, the Plan shall send a Notice of Cancellation, Rescission, or Nonrenewal. This notice shall be sent to the Enrollee and Group:

- At least 30 days before the cancellation, rescission, or nonrenewal for fraud or intentional misrepresentation of material fact.
- At least 180 days before the discontinuation or termination of a contract if the cancellation or nonrenewal is due to the Plan ceasing to provide or arrange for the provision of health benefits for new Plan contracts in the individual or group market.
- At least 90 days before the withdrawal of a health benefit plan from the market pursuant to Health and Safety Code section 1365(a)(6). A notice sent pursuant to this subdivision shall also be sent concurrently to the DMHC.

The Plan shall notify an Enrollee and Group when the plan has cancelled, rescinded, or not renewed health coverage by sending a Notice of End of Coverage. The Plan shall send a Notice of End of Coverage for all cancellations. This Notice shall be sent to the Enrollee and Group after the date coverage ended, and no later than five (5) calendar days after the date coverage ended. This Notice shall be sent after the date coverage ends, and no later than five calendar days after the date coverage ended.

When required pursuant to Health and Safety Code section 1373.96(m), notice as to the availability of the right to request completion of Covered Services shall be part of,

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accompany, or be sent simultaneously with both the Notice of Cancellation, Rescission, or Nonrenewal and the Notice of End of Coverage.

D. 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 issuance of the Notice Confirming Termination of End of Coverage. The Plan shall reinstate the original EAP Services Agreement as though it had never been cancelled.

E. Ending Coverage – Special Circumstances for Enrollees' dependents

Coverage for Enrollees shall terminate on the same date of termination as Group. If there is a divorce, the spouse of Enrollee loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered. Enrollee's dependent children lose their eligibility when they reach the limiting age of 26 and do not qualify for extended coverage as a disabled dependent.

F. Termination for Good Cause

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

1) 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 EAP Providers (or knowingly allow another person to do the same). Plan will provide you with a Notice of Cancellation, Rescission, or Nonrenewal. Termination will be effective on the date specified in the notice of end of coverage, not less than 30 days after such notice. Plan shall send a Notice of End of Coverage after the date coverage ends, and no later than five (5) calendar days after the date coverage ended.

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

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Termination of coverage is effective for all Enrollees, including those who are undergoing treatment for an ongoing condition.

Under no circumstances will an Enrollee be terminated due to health status or the need for Benefits. Any Enrollee who believes his or her enrollment has been terminated due to the Enrollee's health status or requirements for Benefits may request a review of the termination by the California Department of Managed Health Care. For more information, contact our Enrollee Services Department at **1-800-234-5154**.

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 Group.

XVI. CONTINUITY OF CARE

A. New Enrollees

1) Eligibility

Any newly covered Enrollee 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 Clinical Director or Director of Transformation or Operational Excellence 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.

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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 affect 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 Clinical 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. Enrollee 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 EAP Provider following the termination, if the terminated EAP Provider agrees in writing to continue to provide Benefits under the terms and conditions of his/her

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agreement with Plan. To inquire about continued care, you should contact the Member Services Department at **1-800-234-5154**.

XVII. CONTINUATION OF 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 Enrollee.
- Termination of eligibility of a spouse due to divorce or legal separation.
- Termination of eligibility of a dependent child.
- Covered dependent if Enrollee 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 Enrollees, including those Enrollees 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 Enrollees must make payment of Periodic Fees within forty-five (45) days of such written request. Enrollees whose continuation of coverage under COBRA will expire may be eligible for continuation of coverage under Cal-COBRA.

B. Cal-COBRA Continuation of Coverage

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1) Eligibility for Cal-COBRA Continuation Coverage

If Group is subject to the California Continuation Benefits Replacement Act (Cal- COBRA), Enrollees 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 Enrollee is entitled to Medicare.
- Enrollee 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 Enrollees must make payment of Periodic Fees within forty-five (45) days of such written request.

2) Notification of Qualifying Events

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It is the responsibility of the Enrollee 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 Group's benefit plan. Failure to notify Plan within sixty (60) days of the occurrence of a Qualifying Event will disqualify the Enrollee 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 your Cal-COBRA Election Form was received. Failure to send the correct premium amount with forty-five (45) days will disqualify you from continuation coverage under Cal-COBRA. The first premium payment equals the amount of all

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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, an Enrollee'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. Enrollee's Cal-COBRA continuation coverage may terminate early if: Enrollee moves out of Plan's service area; Enrollee does not pay the required premium within fifteen (15) days of it being due; Enrollee commits fraud or deception in using Plan's services; Enrollee obtains other Group coverage.

If the Group benefit plan is terminated prior to the date that an Enrollee's Cal-COBRA continuation coverage would expire, Enrollee's coverage with Plan will expire. Enrollee has the opportunity to continue coverage under the any Group benefit plan purchased by Group. If Group purchases a new plan, that Plan will send Enrollee premium information and enrollment forms. Enrollee may continue coverage for the remainder of the Cal-COBRA continuation period. It is important for Enrollee to keep Plan and Group updated if there are any changes of address. Cal-COBRA continuation coverage will terminate if Enrollee 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, Enrollee's coverage with Plan will expire, and Enrollee 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.

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XVIII. COMPLAINT AND GRIEVANCE PROCEDURE

The Plan has established a Grievance process for receiving and resolving Enrollee complaints. If you experience any problem with services delivered through the Plan, call Member Services at **1-800-234-5154**. You may also submit a complaint or Grievance online at https://go.telushealth.com/en-us/grievance-form, or by mailing notice of your Grievance to:

TELUS Health (California) Ltd.
Member Services
27715 Jefferson Avenue, Suite 103
Temecula, CA 92590

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

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

The Plan will acknowledge in writing receipt of the Grievance within five (5) calendar days and will provide written resolution of the Grievance within thirty (30) calendar days of receipt.

If a Grievance requires urgent attention, the Plan shall expedite its review of the Grievance to be resolved no less than three (3) calendar days of receipt of the Grievance. The Plan is committed to customer satisfaction as a key indicator of quality. Enrollees and EAP Providers have the right to file complaints and Grievances and to attain resolution to their concerns promptly and appropriately.

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

You may file a complaint by phone, in writing, or online at https://go.telushealth.com/en-us/grievance-form. Our toll-free number is **1-800-234-5154** or address your correspondence to:

TELUS Health (California) Ltd.
Attention: Clinical Director

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27715 Jefferson Avenue, Suite 103
Temecula, CA 92590

The Plan does not discriminate against any employee, Provider, Subscriber, or applicant, because of race, religion, color, sex, age, marital status, handicap status, veteran status, sexual orientation, gender identity, gender expression, ancestry or national origin or any other characteristic protected by law. Neither the Plan nor any of its EAP Providers will discriminate against an Enrollee based on the filing of a Grievance. If you believe that you have been discriminated against due to your filing a Grievance, please notify us by calling the Contact Center at 1-800-234- 5154.

A. ENROLLEE PROCESS

Our Grievance policies and procedures have been developed to address Enrollee complaints, quality of care and service issues, and appeals. The Plan's Grievance procedures will be communicated to all Enrollees at the time of enrollment and annually thereafter, by way of the Plan's Combined Evidence of Coverage and Disclosure Form. The Grievance process, a printable Grievance form, and instructions for submitting Grievances online are described and available on the Plan's website at https://go.telushealth.com/en-us/grievance-form or by calling **1-800-234-5154**, or by writing sent to the following address:

TELUS Health (California) Ltd.
27715 Jefferson Avenue, Suite 103
Temecula, CA 92590

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

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

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

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

After researching the issues, the Clinical Director communicates the Plan's decisions to Enrollees.

1) The Plan provides Enrollees with written responses including a clear and concise explanation of the reasons for the Plan's decision.

2) In cases of delay, denial, or modification of services, the criteria used, and the clinical reasons are presented to the Enrollee.

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

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

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B. REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care is responsible for regulating health care services plans. If you have a Grievance against your health plan, you should first telephone your health plan at **1-800-234-5154** and use your health plan's Grievance process before contacting the Department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your health plan, or a Grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website **http://www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

XIX. ARBITRATION

Any and all disputes of any kind whatsoever, including, but not limited to, claims for malpractice (that is as to whether any services rendered under the Benefit Plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered) between Enrollee (including any heirs, successors, or assigns of Enrollee) and Plan, except for claims subject to ERISA, shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Enrollee and Plan are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS. Administration of the arbitration shall be performed by JAMS or such other arbitration services as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

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XX. 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 ENROLLEE UPON REQUEST.

B. Requests for Confidential Communications

If you live in California, you have the right to request all communications regarding your receipt of sensitive services be sent directly to you (either to your contact information on file or to a designated alternative address, email, or phone number).

Requests for confidential communications can be submitted to:

By regular mail: TELUS Health (California) Ltd.
27715 Jefferson Avenue, Suite 103
Temecula, CA 92590

By electronic mail: CFRequests@telushealth.com

By phone: 1-800-234-5154

We will process requests received by email or phone within seven (7) calendar days, and requests received by first-class mail within fourteen (14) calendar days. If you contact us, we will confirm receipt of your request and give you an update on its status.

You do not need to obtain the permission of the primary subscriber or other enrollee in order to receive sensitive services or submit a claim for sensitive services. We will not disclose information related to sensitive health care services you receive to the primary subscriber or any plan enrollees without your express authorization.

Your enrollment or coverage will not be affected by exercising this right.

Requests will be valid until you revoke the request or submit a new one. Requests for confidential communications will apply to all communications that disclose medical information or provider name and address related to your receipt of medical services.

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C. Enrollee Consent

Under the EAP Services Agreement, Group makes Benefits which are consistent with professionally recognized standards of practice, available to Enrollees. 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 Enrollees. By accepting Benefits hereunder, all Enrollees legally capable of contracting, and the legal representatives of all Enrollees incapable of contracting, agree to all terms, conditions and provisions of the EAP Services Agreement.

D. Plan's Policies

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

E. Plan's Public Policy Committee

Plan has established a Public Policy Committee that includes, among others, Enrollees 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 Enrollee desiring more information about this committee should contact Plan at **1-800-234-5154**.

F. Term and Renewal Provisions

The term and renewal provisions are contained in the EAP Services Agreement, subject to the termination provisions contained therein and the "Termination of Benefits" section of this EOC. Plan shall provide written notice, in accordance with the Act and Rules and the "Periodic Fees" section of this EOC, prior to any change in premiums or any other contract provisions.

G. Important Information about Organ and Tissue Donations

There is a need for organ donors across the Country. 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. You can agree to have your organs donated in the event of your death. If you wish to become an organ donor or tissue donor, the California Department of Motor Vehicles (DMV) can give you a donor card that you

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carry with your driver's license or I.D. card, and a donor sticker to place on the front of your driver's license or I.D. card.

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EXHIBIT A – SCHEDULE OF BENEFITS, LIMITATIONS, AND EXCLUSIONS

Employee Assistance Program Services include the following components:

I. Employee Assistance Program

A. Benefits.

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. A "session" is defined as either an in-person or telephone consultation with the Enrollee, of approximately one hour in duration. Sessions are used to identify or work on resolving the issues or conditions that the Enrollee is experiencing. A new incident for the same Enrollee 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.

1) Referrals are offered to Enrollees whose problem cannot be resolved within the short-term model of care. The EAP Provider works with the Enrollee to identify resources of an appropriate type and level of care beyond the benefit.

2) Referrals to other resources are offered to Enrollees if the type of care is outside of the scope of practice of this benefit.

3) 24-hour Crisis Intervention hotline, 7 days/week.

4) Referrals for legal consultation.

5) Referrals for financial counseling.

6) Identity theft consultation.

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B. Limitations

1) The Benefits provided to Enrollees 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 Enrollees, in the event of certain circumstances, such as major disaster, epidemic, riot or civil insurrection.

C. Excluded Benefits

The following services are specifically excluded from Covered Services provided under this Contract. All denials, modification, and delays of requested services are subject to TELUS Health Grievance review process.

1) Emergency Services or treatment.

2) Acupuncture.

3) Aversion Therapy.

4) Biofeedback and hypnotherapy.

5) Services required by court order, or as a condition of parole or probation, not, however, to the Exclusion of services to which the Enrollee would otherwise be entitled.

6) Services for remedial education including evaluation or medical treatment of learning disabilities or minimal brain dysfunction; developmental and learning disorders; behavioral training; or cognitive rehabilitation.

7) Medical treatment or diagnostic testing related to learning disabilities, developmental delays, or educational testing or training.

8) Experimental or Investigational procedures.

9) Services for the management of intellectual disabilities or medical treatment for defects and deficiencies of functional nervous disorders, including chronic mental illness.

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10) Services received from a non-EAP Provider, unless pre-approved by TELUS Health (California) Ltd.

11) Psychological testing (Psychological testing is not necessary to determine an appropriate referral to an EAP Provider to receive Covered Services, or alternatively, to determine appropriate referrals to community resources or Emergency Services for non-Covered Services).

12) Sleep therapy.

13) Examinations and diagnostic services in connection with the following: obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; securing insurance coverage; foreign travel or school admissions.

14) Medical treatment of congenital and/or organic disorders associated with permanent brain dysfunction, including without limitation, organic brain disease, Alzheimer's disease and autism.

15) Medical treatment for speech and hearing impairments (A speech or hearing-impaired Enrollee is entitled to Covered Services. Treatment for speech and hearing impairment is not necessary to determine an appropriate referral to an EAP Provider to receive Covered Services, or alternatively, to determine appropriate referral to community resources or Emergency Services for non-Covered Services).

16) IQ testing (IQ testing is not necessary to determine an appropriate referral to an EAP Provider to receive Covered Services, or alternatively, to determine appropriate referral to community resources or Emergency Services for non-Covered Services).

17) Medical treatment for chronic pain.

18) Services involving medication management or medication consultation with a psychiatrist.

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II. Telephonic WorkLife Program Services

A. Benefits

Our exclusive, phone-based program is designed to assist Enrollees with a full range of WorkLife issues. Enrollees 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 Enrollees ("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 Enrollees, 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 Enrollees themselves or Group, as applicable.

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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 Plan shall be responsible for providing counseling services by an EAP Provider for the following licensed EAP services to the Enrollees: **(a)** Marital or Relationship Difficulties **(b)** Family and Child Problems **(c)** Stress/Anxiety **(d)** Depression **(e)** Grief and Loss **(f)** Substance Abuse **(g)** Domestic Violence **(h)** Job Performance Issues **(i)** Crisis Intervention **(j)** Communication and/or Conflict Issues **(k)** Weight Concerns
D. Outpatient Services	Please see Item C: Professional Services
E. Hospitalization Services	None
F. Emergency Health	None

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Coverage	
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

Enrollees 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.

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