CONCERN: EMPLOYEE ASSISTANCE PROGRAM

AGREEMENT FOR EMPLOYEE ASSISTANCE SERVICES

CITY OF MENLO PARK
2003-2005
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Article</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>RECITALS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARTICLE 1</td>
<td>DEFINITIONS</td>
<td>1</td>
</tr>
<tr>
<td>ARTICLE 2</td>
<td>RESPONSIBILITIES OF THE PLAN</td>
<td>4</td>
</tr>
<tr>
<td>ARTICLE 3</td>
<td>RESPONSIBILITIES OF THE GROUP</td>
<td>5</td>
</tr>
<tr>
<td>ARTICLE 4</td>
<td>RELATIONSHIP BETWEEN THE PARTIES</td>
<td>6</td>
</tr>
<tr>
<td>ARTICLE 5</td>
<td>COVERAGE AND EXCLUSIONS</td>
<td>6</td>
</tr>
<tr>
<td>ARTICLE 6</td>
<td>CHOICE OF PROVIDERS</td>
<td>8</td>
</tr>
<tr>
<td>ARTICLE 7</td>
<td>PREPAYMENT OF FEES</td>
<td>8</td>
</tr>
<tr>
<td>ARTICLE 8</td>
<td>TERM AND TERMINATION</td>
<td>9</td>
</tr>
<tr>
<td>ARTICLE 9</td>
<td>INDIVIDUAL CONTINUATION OF CARE</td>
<td>10</td>
</tr>
<tr>
<td>ARTICLE 10</td>
<td>CONTINUITY OF CARE</td>
<td>11</td>
</tr>
<tr>
<td>ARTICLE 11</td>
<td>GRIEVANCE APPEAL PROCEDURE</td>
<td>12</td>
</tr>
<tr>
<td>ARTICLE 12</td>
<td>ARBITRATION</td>
<td>13</td>
</tr>
<tr>
<td>ARTICLE 13</td>
<td>GENERAL PROVISIONS</td>
<td>15</td>
</tr>
<tr>
<td>ATTACHMENT A</td>
<td>COVERED SERVICES</td>
<td>18</td>
</tr>
<tr>
<td>ATTACHMENT B</td>
<td>COMPENSATION</td>
<td>20</td>
</tr>
<tr>
<td>ATTACHMENT C</td>
<td>CERTIFICATE OF PROFESSIONAL LIABILITY INSURANCE</td>
<td>21</td>
</tr>
</tbody>
</table>
AGREEMENT FOR EMPLOYEE ASSISTANCE SERVICES
PREPAID CONTRACT

This Agreement is entered into between CONCERN: Employee Assistance Program (hereinafter designated “Plan” or “The Plan”) and the City of Menlo Park (hereinafter designated as “Group” or “The Group”) on July 1, 2003 (the “Effective Date”).

RECATIALS

A. The Plan is a specialized health care service plan formed pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended, (“Knox-Keene Act”). The Plan intends to provide assistance to businesses and public organizations in the design, implementation and maintenance of employee assistance programs for the employees of such businesses and public organizations.

B. The Group desires to retain the services of The Plan for the purpose of providing employee assistance services to its employees.

NOW, THEREFORE, THE PARTIES AGREE:

ARTICLE 1

Definitions

1.1 “Agreement” means the Agreement For Employee Assistance Services between The Plan and The Group, including Attachments A and B. Attachments A and B are incorporated herein by this reference.

1.2 “Covered Dependent” means the Subscriber’s spouse, Subscriber’s biological child, or a Subscriber’s adopted child. (Coverage for adopted children of a Subscriber begins on the date on which the adoptive child’s birth parent or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the Subscriber, or the Subscriber’s spouse the right to control health care for the adoptive child, or absent a written document, on the date there exists evidence of the Subscriber’s or Subscriber’s spouse’s right to control the health care of the child placed for adoption.) The Plan shall not deny enrollment of a Subscriber’s child on any of the following grounds: (1) the child was born out of wedlock; (2) the child is not claimed as an exemption on the Subscriber’s federal income tax return; or (3) the child does not reside with the Subscriber or within The Plan’s service area. Covered Dependent children must be unmarried and under the age of 19. Dependent unmarried children who are enrolled in an institution of higher education may continue as eligible dependents through age 25. Dependent unmarried children who are incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who are dependent upon the Subscriber for support and maintenance, are eligible for continuing membership in The Plan.
1.3 "Covered Services" means those services, which are provided by The Plan to Members and set forth in Attachment A to this Agreement.

1.4 "Crisis" means a situation wherein a reasonable person determines there is an immediate need to assess for the possibility of a Medical Emergency Condition or to request services from The Plan relating to an Urgent situation.

1.5 "Crisis Intervention" means the process of responding to a request for immediate services to determine whether or not a Medical Emergency Condition or Urgent situation exists, and to otherwise assess the need for short-term counseling, referrals to community resources, and/or referrals to Medical Emergency Care.

1.6 "Effective Date" means the date stated in the first paragraph of this Agreement as the Effective Date of the Agreement between The Plan and The Group.

1.7 "Employee" means a full-time regular (permanent) employee of The Group in the United States, Canada or Puerto Rico.

1.8 "Employee Assistance Program (EAP) Assessment” means the process of determining, based upon information provided by a Member, the need for either:
   
   (a) Short-term counseling;
   
   (b) Referral(s) to community resources; or
   
   (c) Referral(s) to Medical Emergency Care services or treatment.

1.9 "Employee Assistance Program (EAP) Benefits” means a systematic program to help employees resolve personal problems, such as family conflict, drug or alcohol abuse, stress, marital discord, and other personal problems, and to provide training, consultation, and other management services relating to the effective utilization of this benefit by employers and their employees.

1.10 "Group" or "The Group" means the entity identified in the first paragraph of this Agreement, that executed this Agreement, and employs Employee.

1.11 "Medical Emergency Care” means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if a Medical Emergency Condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the Medical Emergency Condition, within the capability of the facility. This definition also includes additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric Medical Emergency Condition exists, and
the care and treatment necessary to relieve or eliminate the psychiatric Medical Emergency Condition, within the capability of the facility.

1.12 "Medical Emergency 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 usually be expected to result in any of the following:

(a) Placing the patient's health in serious jeopardy.
(b) Serious impairment to bodily functions.
(c) Serious dysfunction of any bodily organ or part.

1.13 "Medicare" means programs for medical coverage set forth in Title XVIII of the Social Security Act (Section 1801 et seq., 42 U.S.C. Section 1385 et seq.) and all amendments thereto.

1.14 "Member" means a person who is enrolled in The Plan and eligible to receive Covered Services.

1.15 "Plan" or "The Plan" means CONCERN: Employee Assistance Program.

1.16 "Plan Provider" means a person who has entered into a provider contract with The Plan to provide Covered Services to Members, and who is licensed in California as either a psychologist, clinical social worker, or marriage and family therapist.

1.17 "Premium" or "Prepayment Fees" means the periodic Premiums set forth in Attachment B, which Group agrees to pay The Plan for Covered Services.

1.18 "Serious Personal Problem or Condition" means circumstances wherein a Member believes he or she requires Covered Services to resolve a Crisis, important or complex matter.

1.19 "Subscriber" means an Employee of The Group who: (a) meets all applicable eligibility requirements of the Agreement; and (b) on whose behalf Group has paid, and The Plan has received, any applicable Premium payments in accordance with the enrollment requirements of the Agreement.

1.20 "Urgent" means a situation in which it is determined that no Medical Emergency Condition exists, however, the Member is in need of immediate telephone support and/or a face-to-face appointment with a Plan Provider within 24-48 hours to resolve a Serious Personal Problem or Condition.

1.21 "Visit" means a session between a Plan Provider and Member of approximately one hour in length wherein the Member, individually or with others, discusses problems with a
Plan Provider in order to resolve the problem. The Member’s problems may consist of family conflict, drug or alcohol abuse, stress, marital discord and other personal problems.

**ARTICLE 2**

**Responsibilities of The Plan**

2.1 Covered Services: The Plan shall provide to The Group those benefits set forth in Attachment “A,” which is appended hereto. Said benefits shall be provided through providers who have agreed to enter into a written contract with The Plan.

(a) All Plan Providers shall be appropriately licensed and shall comply with professionally recognized standards of practice and all applicable state and federal laws.

(b) The Plan shall not decrease in any manner the Covered Services set forth at Attachment “A” except after a period of at least 30 days from and after the postage paid mailing to The Group.

2.2 Quality Assurance: The Plan shall establish and maintain a quality assurance review program throughout the term of this Agreement.

2.3 Confidentiality of Records: The Plan shall comply at all times with the California Confidentiality of Medical Information Act (California Civil Code section 56 et seq.) and any other state or federal law applicable to the services provided under this Agreement. Information related to the identity, medical diagnosis, or treatment provided to any Member shall be kept confidential and shall not be disclosed by The Plan or any Plan Provider to The Group without the prior written consent of the person who is receiving care (or the legal representative of such person). Prior to the release of any confidential information, record, documentation or the like, the Member shall provide to The Plan a signed Release of Information form. The Release of Information form describes in full the extent and scope of information to be released. If a Member has any questions regarding the Release of Information form, he or she should contact The Plan. All records, files or other materials obtained in connection with this Agreement (including those related to individual employees of Group or their families) shall be the property of The Plan. In the event that The Group shall become entitled to disclosure of any medical information in connection with this Agreement, The Plan shall provide The Group with copies of such information only upon the receipt by The Plan from The Group of all costs of copying such information.

2.4 Medical Emergency Care: If a Member feels the situation constitutes a Medical Emergency Condition, the Member should seek care at the nearest hospital emergency room (or trauma center), or immediately call the 9-1-1 operator for emergency assistance. The Plan does not pay for Medical Emergency Care. **Medical Emergency Care treatment is a non-Covered Service.** A Plan Provider can assist the Member in accessing Medical Emergency Care services.
2.5 Crisis Intervention and Urgent Services

(a) The Plan arranges for the provision of Crisis Intervention twenty-four (24) hours a day, seven days a week, to all Members. Members must contact The Plan at 1-800-344-4222 who will make arrangements to provide Crisis Intervention by telephone or in person. Crisis Intervention means the process of responding to a request for immediate services in order to determine whether or not a Medical Emergency Condition or Urgent situation exists and to otherwise assess the needs for short term counseling, referrals to community resources, and/or referrals to Medical Emergency Care or treatment.

(b) Urgent services: Members or a Plan Provider may contact The Plan at any time (24 hours a day) to obtain an EAP Assessment or referrals for care. A Member will be referred to a Plan Provider so that care is provided (1) within 24 to 48 hours in Urgent cases; and (2) within three to five days of a referral for routine appointments. Plan Providers have agreed to see a patient within 30 minutes of his or her scheduled appointment.

2.6 Access to Plan's Processes, Criteria and Procedures for Claim Review

The processes, criteria and procedures that The Plan uses to authorize, modify, or deny employee assistance services under the benefits provided by The Plan are available to the Member, Plan Providers, and the public upon request. Members, Plan Providers and the public may contact The Plan at 1-800-344-4222 to obtain a copy of the processes, criteria and procedures that The Plan uses to authorize, modify, or deny employee assistance services under the benefits provided by The Plan.

2.7 Family Health Insurance Notification

A non-custodial parent of a Covered Dependent child is entitled to inspect the child's Plan Membership, Combined Evidence and Disclosure Form, and all other information provided to the covered parent about the child's coverage. The Plan will also notify both parents (including the non-covered custodial parent) if a Covered Dependent child's coverage is terminated, provided that the parent has provided The Plan with a medical child support order. Lastly, The Plan will respond to telephone or written inquiries from a non-covered custodial parent concerning a child's health coverage.

ARTICLE 3

Responsibilities of The Group

3.1 Information to Members: The Group shall provide Members with information concerning this Agreement, including copies of the combined evidence of coverage and disclosure form, which shall be furnished to The Group by The Plan.
3.2 Provide Headcounts: The Group will provide an accurate headcount of all employees covered by The Plan at the beginning of each month.

3.3 Compensation: The Group shall pay The Plan the Premiums set forth in Attachment “B,” which is appended hereto. The Plan is prohibited from increasing the amount set forth in Attachment “B,” except after a period of at least 30 days from and after the postage paid mailing to The Group.

3.4 Record Retention: Both parties shall maintain all records pertaining to their own performance of duties under this Agreement for a period of seven (7) years from the date on which such records were created, after which time either party may dispose of its records.

ARTICLE 4

Relationship Between the Parties

4.1 Independent Contractor: The Plan shall perform its duties under this Agreement as an independent contractor. Nothing contained in this Agreement shall be construed to create the relationship of principal and agent, employer and employee, partners or joint venturers between the parties.

4.2 Each Party Responsible for its Own Acts: The Plan and The Group are each responsible for their own acts and/or omissions and are not responsible for the acts and/or omissions of the other party, its employees, independent contractors, directors, officers, agents or representatives.

4.3 Insurance: The Plan is covered by professional liability insurance. The coverage is $5,000,000 per claim. A copy of the Certificate of Insurance is attached (Attachment C). The Plan will notify The Group if there is any change in coverage. The Plan also has a Workers’ Compensation Certificate of Consent to Self-Insure.

ARTICLE 5

Coverage and Exclusions

5.1 Coverage: The Plan covers assessments and referrals for care associated with personal and family problems in daily living, short-term counseling and Crisis Intervention. A Member is entitled to a defined number of Visits with a counselor, as set forth in the Covered Services schedule attached hereto as Attachment “A.” The Plan can assist with most personal problems including marital and family problems, difficulty with relationships, emotional distress, job stress, communications or conflict issues, substance abuse issues and loss and death.

5.2 Exclusions: The following services are specifically excluded from Covered Services provided under this Agreement. All denials, modification, and delays of requested services are subject to The Plan’s grievance review process. (See Article 11 for the Grievance Appeal Procedures.)
(a) Services not listed as Covered Services
(b) Medical Emergency Care.
(c) Acupuncture.
(d) Aversion Therapy.
(e) Biofeedback and hypnotherapy.
(f) Services required by court order, or as a condition of parole or probation, not, however, to the exclusion of services to which the Member would otherwise be entitled.

(g) 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.

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

(i) Experimental or Investigational procedures.

(j) Services for the medical treatment of mental retardation or defects and deficiencies of functional nervous disorders, including chronic mental illness.

(k) Services received from a non-Plan Provider, unless pre-approved by The Plan.

(l) Psychological testing (Psychological testing is not necessary to determine an appropriate referral to a Plan Provider to receive Covered Services, or alternatively, to determine appropriate referrals to community resources for non-covered services).

(m) Sleep therapy.

(n) 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.

(o) Medical treatment of congenital and/or organic disorders associated with permanent brain dysfunction, including without limitation, organic brain disease, Alzheimer’s disease and autism.
(p) Medical treatment for speech and hearing impairments. (A speech or hearing impaired Member is entitled to Covered Services. Treatment for speech and hearing impairment is not necessary to determine an appropriate referral to a Plan Provider to receive Covered Services, or alternatively, to determine appropriate referral to community resources for non-covered services.)

(q) IQ testing. (IQ testing is not necessary to determine an appropriate referral to a Plan Provider to receive Covered Services, or alternatively, to determine appropriate referral to community resources for non-covered services.)

(r) Medical treatment for chronic pain.

(s) Services involving medication management or medication consultation with a psychiatrist.

ARTICLE 6

Choice of Providers

The Plan will assign a Plan Provider who will deliver services to a Member. In assigning a Plan Provider to a Member, The Plan will consider where the Member lives and works in relationship to a Plan Provider’s office. Naturally, Plan Providers will be matched with a Member who lives or works in close proximity to a Plan Provider’s office. If the Member prefers to select his or her own Plan Provider, the Member may choose from any available Plan Provider. The Member must state during the initial contact to The Plan representative that he or she prefers to select his or her own Plan Provider and to provide a list of all Plan Providers who have offices in the geographic area where the Member desires to be seen. If the Member is assigned a Plan Provider or selects one he or she is dissatisfied with, the Member may contact The Plan and request to be reassigned a new Plan Provider (or select a new provider from the Plan Provider list).

ARTICLE 7

Prepayment of Fees

No Member shall be obligated in any way to pay for services rendered by The Plan in accordance with the terms of this Agreement, including the payment of any premiums, deductibles, copayments, or co-insurance. By statute, every contract between The Plan and its Plan Providers provides that in the event that The Plan fails to pay the Plan Provider, the Member shall not be liable to that Provider for any sums owed by The Plan. If The Plan fails to pay a non-Plan Provider, the Member could be liable for any sums owed by The Plan.
ARTICLE 8

Term and Termination

8.1 Term: This Agreement shall become effective at 12:01 a.m. on the Effective Date. This Agreement shall continue to remain in full force and effect for a period of two years after the Effective Date unless renewed pursuant to section 8.6 of this Agreement.

8.2 Group Termination: The Group shall have the right to terminate this Agreement immediately upon notice to The Plan in the following circumstances:

(a) Application for or appointment of a receiver, trustee in bankruptcy or liquidator of The Plan;

(b) The Plan’s loss of licensure as a specialized health care service plan pursuant to the provisions of the Knox-Keene Act;

(c) The Plan and The Group’s inability to agree on any payment rate increase or Covered Services provided hereunder.

The Group shall have the right to terminate this Agreement for any other reason by sending written notice of such termination to The Plan. Such termination shall be effective thirty (30) days after the date on which The Group has sent the notice.

8.3 Plan Termination: The Plan shall have the right to terminate this Agreement immediately upon written notice to The Group in the following circumstances:

(a) Application for, or appointment of, a receiver, trustee in bankruptcy or liquidator of The Group;

(b) Failure to Pay the Premiums: Cure of a breach of this obligation to pay the Premium when specified herein, by delivery of the payments to The Plan that places The Plan in receipt of the payments on or before the due date of the succeeding payment, shall reinstate this Agreement as if it had never been terminated. However, The Plan is not obligated to reinstate this Agreement if the payment is received by The Plan more than fifteen (15) business days after written notice of the breach is delivered by The Plan and such payment is refunded to The Group within twenty (20) business days of delivery to The Plan.

(c) The Plan and The Group’s inability to agree on any rate increase or Covered Service provided for hereunder.

(d) The Group commits fraud or deception or knowingly permits such fraud or deception by another in connection with this Agreement.
(e) Upon termination, the respective responsibilities of the parties shall be as follows:

(i) The Plan shall pay Plan Providers for Covered Services by The Plan prior to termination of this Agreement and rendered after such termination.

(ii) The Plan shall use its best efforts to assist The Group in the transfer of Members from Plan Providers to other providers authorized by The Plan.

8.4 Notice of Termination: Upon receipt of any notice of termination from The Plan, The Group shall inform Members of the termination of this Agreement. Group shall mail to each Member within thirty (30) days of termination of this Agreement a legible, true copy of a notice of cancellation and shall provide promptly to The Plan proof of that mailing and the date thereof.

8.5 Notice of Provider Termination: The Plan shall notify The Group within thirty (30) days in the event that a Plan Provider ceases to be a provider for The Plan, or otherwise becomes unable to provide services, if, in the opinion of The Plan, The Group might be materially or adversely affected thereby.

8.6 Renewal: The Plan and Group may renew this Agreement at the end of the term hereof, and by mutual consent modify or alter this Agreement; provided, however, that said modifications, amendments, alteration or renewals shall be in writing, duly executed by both parties hereto. Notwithstanding any other provision of this Agreement, The Plan may amend this Agreement due to changes required by statute, regulation, case law, or other legislation. The Plan shall not increase the amount paid by Group, nor decrease in any manner the benefits stated in the Agreement, unless written notice of such change has been delivered no less than thirty (30) days prior to this Agreement’s renewal effective date.

ARTICLE 9

Individual Continuation of Care

9.1 If a Subscriber terminates his or her employment with The Group for any reason (including death), the Subscriber’s spouse and his or her Covered Dependents are eligible to receive Covered Services from a Plan Provider from whom they are currently receiving care for up to the maximum amount of Visits to which they are entitled, as set forth in the Benefits Schedule. If a Subscriber terminates his or her marriage, and a court of law grants such divorce by issuing a divorce decree, the Subscriber’s former spouse is entitled to receive Covered Services from the Plan Provider from whom he or she is currently receiving care for up to the maximum amount of Visits to which he or she is entitled, as set forth in the Benefits Schedule.

9.2 Members and their Covered Dependents are entitled to receive Covered Services following the Member’s termination of employment if the Member elects to continue coverage through COBRA or Cal-Cobra, as appropriate. Covered Services under COBRA or Cal-Cobra do not include Work/Life services (parenting and childcare resources, older adult resources,
financial services, legal consultations or career management); these are not ERISA-regulated benefits and are provided for The Group’s convenience by The Plan.

ARTICLE 10

Continuity of Care

10.1 When a Member is receiving care from a non-Plan Provider for an otherwise Covered Benefit, if the Member notifies The Plan, prior to or no later than five (5) days after the effective date of coverage, that the Member is currently receiving care from a non-Plan Provider for an otherwise covered condition, The Plan shall either:

(a) Make immediate arrangements to provide care to the Member for the condition through a Plan Provider who shall obtain the charts, if any, and if possible, consult with the non-Plan Provider who has been rendering care to the Member for the acute condition; or

(b) Authorize the Member to continue to receive care from the non-Plan Provider at The Plan’s cost for the condition until The Plan can arrange to transfer the Member’s care for that condition to a Plan Provider. The Plan may elect to pay the non-Plan Provider for up to the limit of the number of Visits the Member is entitled to under the Benefit Schedule.

10.2 In the event a Plan Provider terminates from The Plan and a Member is currently receiving care from such terminated Plan Provider, The Plan requires that the Plan Provider continue to provide care at The Plan’s cost, up to the number of Visits the Member is entitled to under the Benefit Schedule. If for any reason the Plan Provider is not available to complete the care provided, The Plan will make immediate arrangements to provide care to the Member through a transfer to another Plan Provider. All such notifications by a Member may be made to any Plan office. All such notifications shall be forwarded to The Plan’s Clinical Manager for action. The Clinical Manager shall respond to the Member within an appropriate period of time, given the acute condition involved, and in no event more than five (5) days after submission of such notification to The Plan.

10.3 In cases where a Member has an acute condition or serious chronic condition, a Plan Provider shall furnish the Member with Covered Services for 90 days or longer, if necessary, for a safe transfer to another Plan Provider as determined by The Plan in consultation with the Plan Provider, consistent with good professional practice. For purposes of this section, “Acute Condition” means a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention of a limited duration. For purposes of this section, “Serious Chronic Condition” means a medical condition due to a disease, illness or other medical problem or other medical disorder that is serious in nature, and that does either of the following:

(a) Persists without cure or worsens over an extended period of time, or
(b) Requires ongoing treatment to maintain remission or prevent deterioration.

ARTICLE 11

Grievance Appeal Procedure

11.1 The Plan shall establish and maintain grievance appeal procedures, and shall provide The Group with said procedures for dissemination to Members. Those procedures shall include the current address and telephone number for registering grievances with The Plan.

(a) The Plan maintains a Quality Improvement Committee comprised of the Medical Director, who chairs it, two providers and two enrollees of The Plan. The committee shall provide supervision over, and review grievances not resolved by, The Plan’s Medical Director and Clinical Manager. The committee shall have primary responsibility for the review of the grievance procedures, and for the analysis of any patterns that could impact policy changes and procedural improvements in The Plan’s administration.

(b) A Member may file a complaint form about The Plan’s services or that of a Provider by appearing in person or writing or calling The Plan, at:

(800) 344-4222
Clinical Manager
CONCERN: Employee Assistance Program
2400 Grant Road Park Pavilion
Mountain View, CA 94039-7025

Complaint forms and copies of the grievance procedure shall be available at The Plan’s office and at each Plan Provider office. In addition, complaint forms shall be sent to Members on request. Completed forms should be submitted to the above address. Assistance will be provided by a Plan representative to anyone attempting to file a grievance in person or by telephone.

(c) Within three (3) days of receiving a complaint, a Plan representative will contact the complainant to acknowledge receipt of the complaint, to solicit details of the complaint from the Member, and to conduct an investigation. Within thirty (30) days, a Plan representative shall notify the complainant of the disposition of the complaint. If the complaint cannot be resolved by The Plan, the complainant will be advised that he or she may refer the complaint to The Plan’s Quality Improvement Committee for review. If the complainant remains dissatisfied with the proposed resolution recommended by the Quality Improvement Committee, the complainant may request a second level review by The Plan’s Board of Directors. At
any time during the appeal process, the complainant may contact the Department of Managed Health Care at 1-800-400-0815 to request assistance to resolve the grievance. Lastly, the complainant may request binding arbitration. (See Article 12 regarding Arbitration.)

(d) A written record shall be made of each complaint received in person, by mail, or by telephone, including the date, the name of the person recording the complaint, and the resolution. The Clinical Manager will tabulate the types and numbers of grievance being received for periodic review by The Plan’s Board of Directors, the Public Policy Committee, the Quality Improvement Committee and Chief Executive Officer in connection with their consideration and formation of The Plan’s policy. The Quality Improvement Committee shall include in its periodic reports recommended corrective actions to be taken in light of the pattern of grievances received.

(e) Neither The Plan nor any Provider will discriminate against a Member for having filed a complaint. The Quality Improvement Committee will investigate any alleged retaliation and take appropriate action.

11.2 The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number (1-888-HMO-2219) to receive complaints regarding health plans. If The Group or a Member has a grievance against The Plan, The Group or Member should contact The Plan and use The Plan’s grievance process. If The Group or Member needs the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by The Plan, The Group or Member may call the Department's toll-free telephone number. The hearing and speech impaired may use the California Relay Service's toll-free telephone number (1-800-735-2929) (TTY) or (1-888-877-5378) (TTY) to contact the Department. The Department's Internet website (http://www.hmohelp.ca.gov) has complaint forms and instructions online. A Member should also be advised that he or she may contact the Director of the Department if he or she believes Covered Services were cancelled because of the Member’s health status or requirements for employee assistance services.

ARTICLE 12
Arbitration

12.1 Arbitration of Disputes: Any dispute concerning the terms of this Agreement shall be resolved by binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association. Under binding arbitration, both parties give up their rights to have the dispute decided by jury in a court of law. Either party may refer the dispute to the American Arbitration Association for resolution.
12.2 Binding arbitration is the final process for resolution of any dispute or controversy between a Member or personal representatives of the Member, as the case may be, and The Plan over the services provided to the Member under this Agreement for any dispute or controversy concerning the construction, interpretation, performance or breach of this Agreement. The Member agrees that such disputes shall be submitted to binding arbitration under the appropriate rules of the American Arbitration Association ("AAA").

12.3 Each and every disagreement, dispute or controversy, which remains unresolved concerning the construction, interpretation, performance or breach of this Agreement, or the provisions of Covered Services under this Agreement, arising between a Member or eligible dependent or personal representative of such persons, as the case may be, and The Plan, its employees or Plan Provider or their partners, agents or employees, shall be submitted to binding arbitration in accordance with this Section whether such dispute involves a claim in tort, contract or otherwise. This Section does not include disputes involving medical malpractice. It does include any act or omission which occurs during the term of this Agreement but which may give rise to a claim after the termination of this Agreement.

12.4 The Member seeking binding arbitration shall send a written notice to The Plan at the address identified at Section 11.1 of this Agreement. The notice shall contain a demand for binding arbitration and a statement describing the nature of the dispute, including the specific issue(s) involved, the amount involved, the remedies sought and a declaration that the party seeking binding arbitration has previously attempted to resolve the dispute with The Plan. For further assistance, the Member may also write the AAA at 3055 Wilshire Blvd., 7th Floor, Los Angeles, CA 90010-1108, or telephone (213) 383-6515.

12.5 In the case of extreme economic hardship, a Member may request from The Plan information on how to obtain an application for full or partial assumption of the Member's share of fees and expenses incurred by the Member in connection with the arbitration proceedings.

12.6 For all claims or disputes for which the total amount claimed is $200,000 or less, the parties shall select a single neutral arbitrator who shall have no jurisdiction to award more than $200,000. This provision is not subject to waiver, except nothing in this Section shall prevent the parties from mutually agreeing, in writing, after a case or dispute has arisen and a request for arbitration has been submitted, to use a tripartite arbitration panel which includes two party-appointed arbitrators or a panel of three neutral arbitrators, or another multiple arbitrator system mutually agreeable to the parties. The agreement shall clearly indicate, in boldface type, that "A case or dispute subject to binding arbitration has arisen between the parties and we mutually agree to waive the requirement that cases or disputes for which the total amount of damages claimed is two hundred thousand dollars ($200,000) or less be adjudicated by a single neutral arbitrator." If the parties agree to waive the requirement to use a single neutral arbitrator, the Member or Subscriber shall have three business days to rescind the agreement. If the agreement is also signed by counsel of the Member or Subscriber, the agreement shall be binding and may not be rescinded. If the parties are unable to agree on the selection of a neutral arbitrator, The Plan shall use the method provided in section 1281.6 of the Code of Civil Procedure to select the arbitrator.
12.7 The parties agree that the arbitrator(s) shall issue a written opinion, and the award of the arbitrator shall be binding and may be enforced in any court having jurisdiction thereof by filing a petition of enforcement of said award. The findings of the arbitrator and the award of the arbitrator issued thereon shall be governed by the applicable state and federal statutory and case law. The arbitrator's award shall be accompanied by a written decision explaining the facts and reasons upon which the award is based, including the findings of fact and conclusions of law made and reached by the arbitrator(s). The decision shall be signed by the arbitrator(s) in order to be effective.

12.8 The declaration of a court or other tribunal of competent jurisdiction that any portion of this Agreement to arbitrate is void or unenforceable shall not render any other provision hereof void or unenforceable.

12.9 The arbitrator(s) shall make the necessary arrangements for the services of an interpreter upon the request of any party, which party shall assume the cost of such services.

12.10 The arbitration shall take place in the largest city or town in the county where Covered Services were provided, unless some other location is mutually agreed upon by the parties, and shall be governed by the rules of the American Arbitration Association. The expenses of the arbitrator(s) shall be shared equally by the parties.

ARTICLE 13

General Provisions

13.1 Notice: All notices required by this Agreement shall be in writing, shall be sent by United States mail, certified or registered, return receipt requested, postage pre-paid, to The Plan or The Group at their respective addresses set forth on the signature page of this Agreement. If mailed in accordance with the above, such notice shall be deemed to be received three (3) business days after mailing. The Group or The Plan shall notify the other party in writing within thirty (30) days of a change of address to which notices are to be sent.

13.2 Member Non-Liability: Pursuant to the provisions of the Knox-Keene Act, in the event that The Plan fails to pay a Plan Provider for any sums owed for Covered Services rendered to a Member, the Member shall not be liable in any way to the Plan Provider. In the event The Plan fails to pay a non-Plan Provider for services rendered to a Member, the Member may be liable to the non-Plan Provider for the cost of the services received.

13.3 Plan Subject to the Provisions of Knox-Keene Act: The Plan is subject to the requirements of Chapter 2.2 of Division 2 of the Health and Safety Code and Sub-Chapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations and any provisions required to be in this Agreement by either of the above, and shall bind The Plan whether or not provided in this Agreement.
13.4 Review By the Director of the Department: If any person believes that a Member has been canceled or denied eligibility or services under the Agreement because of a Member's health status or requirements for EAP benefits, he or she may request a review by the Director of the Department of Managed Health Care of the State of California under Section 1365(b) of the California Health and Safety Code.

13.5 Amendments: This Agreement may be modified or amended only by a written amendment signed by both parties.

13.6 No Third Party Beneficiaries: Neither party may assign its rights or delegate its duties under this Agreement without the other party's prior written approval, except that The Plan may make such assignment and/or delegation to an affiliate provider without any such prior written approval.

13.7 Attachments and Interpretation: All Attachments are incorporated into this Agreement at the point of their reference.

13.8 Governing Law: This Agreement shall be governed by the laws of the State of California and in particular the Knox-Keene Act and accompanying regulations.

13.9 Non-Discrimination: Neither party may discriminate in any way against any person on the basis of age, sex, race, color, creed, physical or mental impairment or handicap, marital status, sexual orientation, or national origin in connection with or related to the performance of this Agreement.

13.10 Prior Agreements: This Agreement represents the entire understanding and agreement of the parties as to those matters contained in it. No prior oral or written understanding shall bring any force or effect with respect to such matters.

13.11 Severability: If any provision of this Agreement is determined to be illegal or unenforceable, that provision shall be severed from this Agreement, and the remaining provisions shall remain enforceable between the parties.

13.12 Waiver: No waiver of any provision of this Agreement shall be effective against either party unless it is in writing and signed by the party granting the waiver. Failure to exercise any rights shall not operate as a waiver of such right.

13.13 Authority to Execute: By their signature below, each of the following persons represent that they have the authority to execute this Agreement and to bind the party on whose behalf their execution is made.
NOTICE: By accepting the terms of this Agreement, you are agreeing to have all issues decided by binding arbitration and are giving up your right to a jury trial. See Section 12 of this Agreement.

CONCERN: Employee Assistance Program

The City of Menlo Park

Name sign: Céulé Currier
Name print: Céulé Currier
Title: CEO
Date: 6/17/03

2400 Grant Road, Park Pavilion
M/S PAR G17
Mountain View, CA 94040

Name sign: Glen H. Kramer
Name print: Glen H. Kramer
Title: PERSONNEL & INFORMATION SERVICES DIRECTOR
Date: 6/10/03

701 Laurel
Menlo Park, CA 94015
Attachment A

COVERED SERVICES

BENEFIT SCHEDULE

The Plan shall provide the following Covered Services:

A. EAP Assessment, referral to community resources and Medical Emergency Care, and short-term counseling. The Plan offers counseling services for a wide range of personal problems and immediate response for Crisis situations. Each enrollee shall be limited to a maximum of ten (10) Visits and his or her Covered Dependents shall be limited to a maximum of four (4) Visits for each problem per twelve-month period, beginning with the date of the case opening. If a Covered Dependent is assessed as having a chemical dependency problem, the maximum number of visits shall be increased from four (4) to ten (10). For the purpose of this provision, the word “problem” means a specific type of matter, situation or issue of concern to a Member for which the Member requests EAP services for purposes of obtaining assistance in arriving at a solution. CONCERN provides counseling for the following “problem” issues:

(i) marital and family problems,
(ii) difficulty with relationships,
(iii) emotional distress,
(iv) job stress,
(v) communications or conflict issues,
(vi) substance abuse issues and
(vii) loss and death issues.

B. The Plan provides a problem-focused form of individual or family outpatient counseling that

(i) seeks resolution of problems in living rather than basic character changes;
(ii) emphasizes the Member’s skills, strengths and resources;
(iii) involves setting and maintaining realistic goals that are achievable in a one to five month period; and
(iv) encourages the Member to practice behavior outside the counseling Visits to promote therapeutic goals.

C. The Plan's EAP services will provide Members with confidential EAP Assessment, Crisis Intervention, short-term counseling and referral to community resources. The Plan can also refer you to individuals who are licensed to provide parenting and childcare resources, older adult resources, legal consultations, financial services and help with career management.

D. Upon reaching the maximum number of Visits, a Member may continue to receive services by the Plan Provider, but at the Member's expense. Upon each case opening, The Plan shall inform the Member of the number of Visits he or she is entitled to receive.

E. A Plan Provider will also refer a Member to community resources for assistance for non-Covered Services. In the event of such referral, the Member shall be advised by The Plan and the Plan Provider that the Member is responsible for payment of costs and fees for services provided.

F. The Plan Provider shall also obtain from a Member a consent form prior to the release of any information concerning said Member, except as required by law. A Plan Provider shall explain such form to each Member.

G. Upon request, The Plan shall provide up to 5 hours per contract year of on-site educational seminars and up to 5 hours of crisis response. Seminars are to be selected from a list of topics provided by The Plan. Cancellations of educational seminars within 3 business days (72 business hours) of their scheduled time shall be counted as used on-site hours, or subject to a late cancellation billing of $250, whichever applies. Additional on-site hours may be purchased at $250 per hour. Note: Critical Incident Stress Management services for sworn officers are not included as part of "on-site crisis counseling." Sworn officers shall have the services of the Critical Incident Stress Management team (CISM) available to them on a 24-hour, 7-days-a-week basis. CISM provides a 20-minute response time to telephone calls and a 60-minute response time to requests for on-site debriefing. CISM also provides debriefing 24-32 hours post event. CISM hours shall be billed at $300/hr.

H. The Plan shall conduct management orientation sessions for The Group's management and supervisory personnel and employee orientation sessions for The Group's personnel at such times and locations as are mutually agreed upon by The Plan and The Group. The Plan shall provide up to 2 hours of orientation.

I. Upon request, The Plan shall consult with The Group's Human Resources staff and individual supervisors and managers regarding potential or actual supervisory referrals and employee performance issues.

J. The Plan shall provide quarterly reports. Such reports shall include statistics on number of employees using The Plan, demographics, referral sources, services used and problem types.
Attachment B

COMPENSATION


B.2 Invoices. The Plan will invoice The Group monthly based on an accurate headcount of all employees covered by The Plan, to be provided by The Group at the beginning of each month. All amounts due under this Agreement shall be paid to The Plan within 30 days of receipt of said invoice. Invoice shall be remitted to:

CONCERN: EAP
Department 33079
P.O. Box 39000
San Francisco, CA 94139-3079

All invoices for services are due upon receipt. In the event that payment is not received within 30 days of invoice date, a finance charge of 1.5% (18% annually) will be applied.

Tax I.D. number for The Plan is 77-0528349.
BETA Healthcare Group, A Public Entity

CERTIFICATE OF PARTICIPATION
HEALTHCARE ENTITY COMPREHENSIVE LIABILITY COVERAGE CONTRACT

NOTICE: THIS IS A CLAIMS MADE AND REPORTED CONTRACT WHICH APPLIES ONLY TO "CLAIMS" THAT ARE FIRST MADE AGAINST THE MEMBER AND REPORTED IN WRITING TO BETA HEALTHCARE GROUP AS SOON AS POSSIBLE AND IN NO EVENT LATER THAN SIXTY (60) DAYS AFTER THE CONTRACT EXPIRATION DATE. IN ADDITION, THIS COVERAGE CONTRACT PROVIDES NO COVERAGE OR DEFENSE FOR ACTS, ERRORS, OMISSIONS, OFFENSES OR "OCCURRENCES" WHICH OCCUR PRIOR TO THE "RETROACTIVE DATE." THE COVERAGE AFFORDED BY THIS CONTRACT DIFFERS IN SOME RESPECTS FROM THAT AFFORDED BY MOST INSURANCE POLICIES. PLEASE READ IT CAREFULLY.

<table>
<thead>
<tr>
<th>ITEM 1: NAMED MEMBER:</th>
</tr>
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<tbody>
<tr>
<td>El Camino Hospital District</td>
</tr>
<tr>
<td>2500 Grant Road</td>
</tr>
<tr>
<td>Mountain View, CA 94039-7025</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 2: SUBSIDIARIES:</th>
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</thead>
<tbody>
<tr>
<td>El Camino Hospital, El Camino Hospital Auxiliary, Inc., El Camino Hospital Foundation, El Camino Surgery Center(s) partnership), Concern: EAP</td>
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</table>

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<tr>
<th>ITEM 3: CONTRACT PERIOD:</th>
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<tbody>
<tr>
<td>(a) Effective Date: 7/1/02</td>
</tr>
<tr>
<td>(b) Expiration Date: 7/1/03</td>
</tr>
<tr>
<td>(c) Retrospective Date: 1/1/93 (except as by Amendment)</td>
</tr>
<tr>
<td>(d) Time: 12:01 a.m. local time for all dates at the address in Item 1</td>
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</tbody>
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<tr>
<th>ITEM 4: LIMIT OF LIABILITY:</th>
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<tr>
<td>$20,000,000 per Claim (except as provided by Amendment)</td>
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<tr>
<td>$20,000,000 in the Aggregate</td>
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<tr>
<th>ITEM 5: DEDUCTIBLE:</th>
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<tbody>
<tr>
<td>See Section 7.9.B</td>
</tr>
<tr>
<td>$100,000 Shared</td>
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<tr>
<th>ITEM 6: CONTRIBUTION:</th>
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<tbody>
<tr>
<td>See Section 7.9.A</td>
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</tbody>
</table>

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<tr>
<th>ITEM 7: CONTRACT AND AMENDMENT FORMS ATTACHED AT ISSUANCE: HCLCM(07/02)</th>
</tr>
</thead>
<tbody>
<tr>
<td>120(1), 130(1), 131(16), 132(1), 134(1), 145(1), 172(1), 186(1), 191(1), 194(1), 195(1), 203(1), 210(1), 290(2)</td>
</tr>
</tbody>
</table>

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<tr>
<th>ITEM 8: NOTICE REQUIRED TO BE GIVEN TO BETA HEALTHCARE GROUP MUST BE ADDRESSED TO:</th>
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</thead>
<tbody>
<tr>
<td>BETA Healthcare Group</td>
</tr>
<tr>
<td>1443 Danville Boulevard</td>
</tr>
<tr>
<td>Alamo, CA 94507</td>
</tr>
</tbody>
</table>

This Certificate of Participation, the Application(s) and accompanying documents, and the Coverage Contract with Amendments shall constitute the Contract between BETA Healthcare Group and the Members.

Authorized Representative of Named Member

Authorized Representative of BETA Healthcare Group

Signed: [Signature]
CONCERN: EMPLOYEE ASSISTANCE PROGRAM  
AMENDMENT #7 TO AGREEMENT FOR EMPLOYEE ASSISTANCE SERVICES  
FOR  
City of Menlo Park  

This Amendment #7 is entered into between CONCERN; Employee Assistance Program ("The Plan") and City of Menlo Park ("The Group") on July 1, 2015 (the "Effective Date").  

WHEREAS, The Plan and The Group entered into that certain Agreement For Employee Assistance Services on July 1, 2003, as amended by the First, Second, Third, Fourth, Fifth and Sixth Amendments (collectively, the "Agreement") pursuant to which The Plan would provide certain employee assistance services to The Group’s eligible employees and their eligible dependents.  

NOW, THEREFORE, THE PARTIES AGREE:  

Attachment B – COMPENSATION of The Agreement is amended in its entirety and replaced with the following:  

B.1 Compensation. From July 1, 2015 to June 30, 2018, The Group shall pay $5.75 per employee per month for Covered Services. If the Group’s headcount drops below one hundred and fifty (150) employees during a contract year or the total invoiced amount for that contract year is less than six thousand five hundred dollars ($6,500), the difference between the total invoiced amount and six thousand five hundred dollars ($6,500) shall be due and payable to The Plan at the end of the contract year.  

B.2 Invoices. The Plan will invoice The Group monthly based on an accurate headcount of all employees covered by The Plan, to be provided by The Group at the beginning of each month. All amounts due under this Agreement shall be paid to The Plan within 30 days of receipt of said invoice. Payment shall be remitted to:  

CONCERN: EAP  
Department 33079  
P.O. Box 39000  
San Francisco, CA 94139-3079  

All invoices for services are due within 30 days of receipt. In the event that payment is not received within 30 days of invoice, a finance charge of 1.5% (18% annually) will be applied.  

Tax I.D. number for The Plan is 77-0528349.  

Except as set forth above, all terms and conditions of The Agreement and subsequent modifications remain unchanged and in full force and effect.  

Accepted and Agreed:  

CONCERN: Employee Assistance Program  
Name sign:  
Name print: James E. Harris  
Title: Director  
Date: 6/29/15  
1503 Grant Road, Ste. 120  
Mountain View, CA 94040  

City of Menlo Park  
Name sign:  
Name print: Alex D. McIntyre  
Title: City Manager  
Date: 6/30/2015  
701 Laurel Street  
Menlo Park, CA 94025
CONCERN: EMPLOYEE ASSISTANCE PROGRAM
AMENDMENT #7 TO AGREEMENT FOR EMPLOYEE ASSISTANCE SERVICES
FOR

City of Menlo Park

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Name print: James E. Harris
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701 Laurel Street
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