SECOND MODIFICATION TO

EMPLOYEE ASSISTANCE PROGRAM CONTRACT

WHEREAS, on May 5, 2021atheaDepartment entered into a contract with the Contractoraa for the Employee Assistance Program, Project No. F10B0600055, (the "Contract") pursuant toaa the Request for Proposals for the Employee Assistance Program, Project No. F10B0600055aa dated May 22, 2020, and all amendments thereto issued in writing byathe State (theá'RFP"); and

WHEREAS, the Department and Contractor modified the Contract on September 9, 2021aa to change the Contractor's response time upon submission of an EAP Supervisory Referral Formaa by the State EAP Coordinator to the Contractor Account Executive ("Modification 1"); andaa

aaWHEREAS, the Department and Contractor now desire to modify the Contract to removeaa reporting of substance abuse referral by drug class, to revise the Supervisory Referral Form and to amend certain reporting dates.

NOW THEREFORE, IN CONSIDERATION of the promises and the covenants herein contained, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1.aaRFP. Section 2.3.10.1 of the RFP is hereby deleted in its entirety and replaced as follows:aa

2.3.10.1 All Contractor reports shall be in the form and format as approved by the Contract Manager. All required fields shall be filled in correctly prior to submission.

Utilization: The Contractor Account Executive shall provide monthly, quarterly and annual aggregate reporting of plan utilization and activity data. For all referrals, detail information shall include but not be limited to, problem areas, open cases, closed cases, online or in-person location of EAP counseling sessions, timeliness of appointment scheduling, gender of employees, age ranges, marital status, agency, referral source and referral outcome, employee home zip code, previous contact with the EAP, insurance information (Health Plan), employee type, time type, union information (including bargaining unit), eligibility status (employee, dependent, household member), referral source (self, state employee, supervisor), presenting issues, type of specialist/provider to which the caller was referred, setting (telephonic/chat/email/in-person),

distance to in person provider, number of sessions scheduled, number of sessions completed, number of sessions missed, number of sessions for ineligible participants, type of referral beyond EAP, and satisfaction results.

The utilization reports shall be submitted to the Contract Manager within seventy-five (75) calendar days following the end of the preceding month, quarter and year.

2. RFP Technical Proposal Attachment T-6. RFP Technical Proposal Attachment T-6 Compliance Checklist Sections CC-34 and CC-35 are hereby deleted in their entireties and replaced as follows:

	Monthly reports include	Offeror's .Response
CC-34	Reporting of plan utilization and activity data, including but not limited to utilization by department/agency: number of referrals, source, presenting issues, open cases, closed case, number sessions per referral (of the session available per episode per year), number of sessions for ineligible participants, and the average number of sessions per episode. For Supervisor referrals number of sessions per supervisor referral (of 'the 2 sessions per year), location of EAP counselling sessions, timeliness of appointment scheduling, Agency, and referral outcome. Report shall be submitted to the Contract Manager with seventy-five (75) calendar days following the end of the preceding month. This report shall be in the form and format approved by the Contract Manager after contract commencement. (See Section 2.3.10)	Choose
	Quarterly reports include:	
CC-35	Reporting of plan utilization and activity data, including but not limited to utilization by department/agency: number of referrals, source, presenting issues, open cases, closed case, number sessions per referral (of the session available per episode per year), number of sessions for ineligible participants, and the average number of sessions per episode. For Supervisor referrals number of sessions per supervisor referral (of the 2 sessions per year), location of EAP counselling sessions, timeliness of appointment scheduling, Agency, and referral outcome. Report shall be submitted to the Contract Manager with seventy-five (75) calendar days following the end of the preceding month. This report shall be in the form and format approved by the Contract Manager after contract commencement. See PG-7 in "Attachment T-9: Performance Guarantees"	Choose

3. RFP. Appendix 3 to the RFP, "EAP Supervisory Referral Form," is hereby replaced in its entirety with the EAP Supervisory Referral Form attached hereto as Exhibit A.

4. RFP Technical Proposal Attachment T-9. RFP Technical Proposal Attachment T-9 Performance Guarantees Sections PG-6 and PG-7 are hereby deleted in their entireties and replaced as follows:

	T****		T	T	1
PG-6	Delivery of Quarterly Plan Performance Measurement Report Card to the State	Delivery to the State by 6:00 pm on the following dates First Quarter (Sep-Nov) Due: February 15th Second Quarter (Dec-Feb) Due: May 15th Third Quarter (Mar-May) Due: August 15th Fourth Quarter (June-August) Due: November 15th	Date-stamp of receipt by the State. Frequency of report: Quarterly	\$1,500 for each week, or fraction thereof that Report Card is not received.	Choose
PG-7	Delivery of Quarterly Utilization Reports to the State	Delivery to the State by 6:00 pm on the following dates First Quarter (Sep-Nov) Due: February 15th Second Quarter (Dec-Feb) Due: May 15th Third Quarter (Mar-May) Due: August 15th Fourth Quarter (June-August) Due: November 15th	Documentation of receipt by State, i.e., date-stamp of mailing package or data information and verification of completeness. (All required fields must be filled in correctly.) Frequency of report: Quarterly	\$1,500 for each week, or fraction thereof that Quarterly Report Card is not received.	Choose

- 5. Consideration and Payment. Payment to the Contractor for the services under the Contract shall remain the same as stated in the Contractor's Financial Proposal, RFP Attachment B, dated February 10, 2021, and shall not exceed \$3,098,038.00.
- **6.Scope of Second Modification.** This Second Modification amends the Contract specifically as described herein. Except as specifically revised by the terms of this Second Modification, all

of the terms of the Contract shall remain in full force and effect and shall apply to this Second Modification.

[signature page follows]

Exhibit A

EAP Supervisory Referral Form

IN WITNESS THEREOF, the parties have executed this Second Modification as of the date hereinabove set forth.

CONTRACTOR:	STATE OF MARYLAND:
JANUS ASSOCIATES, INC., DBA "BHS"	DEPARTMENT OF BUDGET AND MANAGEMENT
Dawn Digitally signed by Dawn Motovidlak Date: 2022.05.05 15:07:18 -04'00'	Mare Theolo,
Ву:	By: Marc Nicole, Deputy Secretary
Dawn Motovidlak, President & CEO	Or designee:
Print Name and Title	
5/5/2022	5/25/22
Date	Date
Michal A. Moffitt	· · · · · · · · · · · · · · · · · · ·
Witness/Attest	Witness
Approved for form and legal sufficiency	•
this 11th day of May , 2022. Damon A. Brown	· · · · · · · · · · · · · · · · · · ·
Aggistant Attornay Canaral	

Exhibit A

EAP Supervisory Referral Form

Appendix 3. EAP Supervisory Referral Form CONFIDENTIAL STATE OF MARYLAND - EAP SUPERVISORY REFERRAL FORM

The purpose of this form is to provide information to the Employee Assistance Program (EAP) regarding an employee who may have a personal problem that may negatively impact (or has negatively impacted) their job performance. Additionally, please note that the EAP contractor will inform the State's EAP Coordinator of each instance where an employee attends or fails to attend a scheduled EAP counseling session. THIS FORM MUST BE SUBMITTED TO THE EAP COORDINATOR. IN THE SPACE PROVIDED PLEASE WRITE A BRIEF SYNOPSIS EXPLAINING THE BASIS FOR REFERRAL.

Please print legibly in ink or type.		REFERRAL DATE:		
COMPLETE EMPLOYEE INFO	RMATION BELOW:			
EMPLOYEE'S NAME:				
GENDER:□ FEMALE □ MALE □ 1	NON-BINARY/THIRD GENDER 🗆 P	REFER TO SELF-DESCRIBE PREFER NOT TO SAY		
HOME ADDRESS:				
HOME PHONE:	(Address, City, State,WORK PHONE:	and Zip Code)CELL PHONE:		
WORK EMAIL:	PERSONAI	EMAIL:		
CLASSIFICATION:		GRADE:		
START DATE:	DATE OF BIRTH:	MARITAL STATUS:		
DEPARTMENT/AGENCY NAME:	(Do not use ac			
		cronyms)		
WORK ADDRESS:	(Address, City, Sta	te and Zin Code)		
WORK HOURS/SHIET.		DAYS OFF:		
(Use 12-	hour clock - DO NOT use military time)	DAYS OFF:		
COMPLETE AGENCY CONTAC	T INFORMATION BELOW:			
SELECT REFERRAL TYPE:	SUPERVISORY	MANAGEMENT		
REFERRED BY:		PHONE:		
TITLE:		FAX:		
AGENCY EAP REPRESENTATIVE	!:	PHONE:		
TITLE:		FAX:		
AGENCY EAP REPRESENTATIVE	EMAIL:			
MAILING ADDRESS:		·		
Agency EAP Representative (Print Name)	Agency RAP Representative (Signature)		

CONFIDENTIAL REASON FOR REFERRAL

FORM COMPLETION STEPS

#1: Select referral type.
#2: Select each applicable subcategory as it relates to the requested referral type.

#3: Attach all supporting documentation and/or provide a synopsis that supports referral type and corresponding subcategories.

[☐ SUBSTANCE ABUSE REFERRAL		
	VIOLATION OF GOVERNOR'S EXECUTIVE ORDER	R REGARDING SUBSTANCE ABUSE:	YES/NO (Circle One)
	Failed random drug test	Alcohol related conviction	Other
•	MENTAL HEALTH REFERRAL	ž. 12	
	ATTENDANCE (Please place numbers where numbers are re	equested)	
	# of days absent in past 12 month	# of extended lunches past six (6	6) months
	# of times late in past six (6) months	Pattern (e.g., Mondays, Fridays,	
	Other	after holidays). Please describe:	
	JOB PERFORMANCE (Please provide supporting docume	entation for any items checked below);	
	Lower quality of work	Erratic work patterns	
	Decreased productivity	Failure to meet schedules	
	Increased errors	Inability to concentrate	
	Impaired judgment/memory	Other	3
	BEHAVIOR DEMONSTRATED WITH RESPEC	T TO JOB PERFORMANCE	è
	Avoids supervisors/coworkers	Unusually sensitive to advice/co	nstructive criticism
	Less communicative	Unusually critical of supervisor/	coworkers/employer
	Disregard for safety	Frequent mood swings	e
	Loss of interest	Other	

CONFIDENTIAL SYNOPSIS Have the above issues been discussed with employee? Yes/No (Circle One) Has employee been referred to State Medical Director? Yes/No (Circle One) IF EMPLOYEE INTENDS TO PARTICIPATE, THIS REFERRAL CANNOT BE PROCESSED WITHOUT "YES" INDICATED BELOW AND THE EMPLOYEE'S SIGNATURE I understand that my employer is referring me to the State Employee Assistance Program. I also understand that my signature below does not reflect my agreement or disagreement with any of the issues raised. My signature verifies that I have seen this referral and all documentation contained therein and that I consent to and authorize the EAP Contractor to release my attendance, or lack thereof, and/or my compliance with the EAP Contractor's recommendations, to the State EAP Coordinator, Contract Manager and DBM Employee Relations Officer for the sole purpose of auditing the EAP Contractor's performance. The types of information that may be disclosed for the purpose of auditing Contractor performance are as follows: number of sessions per supervisor referral, location of EAP counseling sessions, timeliness of appointment scheduling, gender of employees, age ranges. marital status, agency, city of EAP counselor, and referral outcome. I understand this consent becomes effective on the date I sign it and will continue in effect for the duration of the contract term between the State Employee Assistance Program and EAP Contractor, including any optional years and retention periods I understand I have the right to revoke this authorization at any time, by following the revocation procedures described in the Notice of Privacy Practices. I understand that I am entitled to receive a copy of this authorization upon request. I agree that a photocopy or facsimile copy of this signed form is as valid as an original signed copy. I understand that after this information is disclosed, federal law might not protect it, and the recipient may re-disclose it. I agree to release the above-named individual(s) or organization(s) and the EAP, the EAP counselor, and his/her designee from liability that may result from furnishing this information as authorized in this disclosure, YES, I will participate in the Employee Assistance Program___NO, I will not participate in the Employee Assistance Program Name of Health Insurance Carrier Employee Signature Date Your agency EAP Representative will securely forward this form and all supporting documentation to: EAP.DBM@maryland.gov or 410-333-7603 (fax) If you have questions, please contact the Employee Assistance Program at 410-767-5846 or 410-767-1314.

FAILURE TO COMPLETE THIS FORM LEGIBLY AND FULLY WILL RESULT IN APPOINTMENT DELAY.

STATE EAP COORDINATOR ONLY			
URGENT: Yes/No (Circle One)	DATE:	***************************************	
COMMENTS:			
DISTRICT NI ARADS.	CYCON A PRIDE		