CONCERN: Employee Assistance Program

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM (EOC/DF)

FOR

Superior Court of California - County of Santa Barbara

CONCERN: Employee Assistance Program
2490 Hospital Drive, Suite 310
Mountain View, CA 94040
(800) 344-4222

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The purpose of the EOC/DF is to provide you with a summary of the contract between Public Risk Innovation, Solutions and Management [PRISM], a California Joint Powers Authority or JPA ("the Group") on behalf of its Members Superior Court of California - County of Santa Barbara and CONCERN: Employee Assistance Program ("Concern" or "the Plan") and the services offered to Employees of the Member Organizations.

This combined EOC/DF constitutes only a summary of the terms, conditions, and benefits of coverage offered. The agreement for employee assistance services must be consulted to determine the exact terms and conditions of coverage. This document will help you understand your rights and responsibilities as an EAP user. For more information about benefits that you are entitled to receive, please contact either CONCERN: Employee Assistance Program at (800) 344-4222 or your Employer to obtain a copy of the agreement for employee assistance services.

You have the right to review this document prior to receiving covered services. This document should be read completely, and individuals with mental health needs should read carefully those sections that apply to them. For meanings and limitations of terms, see the Definitions section of this document. This EOC is subject to change without notice and without your consent. Please refer to the most recent EOC as benefits may have changed since the version you reviewed.

By accepting services under this Plan, EAP users agree to abide by all terms, conditions and provisions in the Agreement and this EOC. Clients must notify the Plan of any change in residence, and any circumstances that may affect entitlement to coverage or eligibility under the Plan. Clients cannot transfer coverage and benefits of this Plan to another person. The Plan can deny requests for transfer of coverage, and reserves the right to make payment for services, at its sole discretion, directly to the Plan Provider or Vendor Partners for rendered services.

As a condition of enrollment and to receive benefits, the Plan, its agents, partner vendors, independent contractors and Plan Providers shall be entitled to release to, or obtain from, any person, organization or government agency, any information and records, including patient records of Clients, which the Plan requires or is obligated to provide pursuant to legal process, or federal, state or local law. Each Client expressly consents to, authorizes and directs Plan Providers, or others giving treatment or advice, to make available to the Plan, such medical, mental health reports, records and other information or copies thereof, as the Plan may request for the purposes of administering this Plan.

1. INTRODUCTION TO THE PLAN

CONCERN: Employee Assistance Program ("the Plan") is an employee assistance plan offered to employees, their spouses or domestic partners and children, at no cost to Clients. Services are paid for by the Employer. If you meet the eligibility requirements established by your Employer, you are automatically enrolled into the Plan.

2. CHOICE OF PROVIDER

(a) Choosing a Plan Provider

The Plan maintains a panel of licensed Plan Providers who have been recruited and are monitored by the Plan. The Plan Providers offer counseling services in-person, or virtually, or both (hybrid model). The Plan also contracts with a Telehealth partner to offer virtual counseling services to its Clients. Referral and prior authorization are always required for EAP services. You can request an appointment with the Plan Providers or Virtual Counseling Partner's Providers by calling the Plan's Access Center at 1-800-344-4222 during business hours, or through the Plan's digital access. In some cases, the Plan may share a list of Providers for you to choose from.

Although the Plan updates its Plan Provider list on a regular basis to ensure availability, the Plan cannot guarantee the initial or continued availability of any particular Plan Provider.

If you are referred to a Plan Provider or select one who you are dissatisfied with, you may contact the Plan and request referral to a new Plan Provider. To receive information and assistance, contact the Plan at **(800) 344-4222.** This phone number is available 24 hours a day, 7 days a week. You may call and request a Plan Provider during regular business hours. After regular business hours your name and telephone number will be taken and you will be called on the next day with the name of a Plan Provider or you may choose to go with a provider for virtual counseling from the Plan's Digital Platform.

(b) Telehealth

You may receive Covered Services on an in-person basis or via telehealth from a Plan Provider or the Plan's virtual counseling partner. There is no cost to you whether those Covered Services are provided to you in person or via telehealth, and there is no difference in the cost to your Employer whether those services are provided in-person or via telehealth. Both in-person and telehealth services will count against your available number of Visits

If you receive services through a third-party corporate telehealth provider, you will be asked to provide your primary care provider's information at the time you request services. Your information will be shared with your primary care provider. You may object to sharing your information at the time you request services.

(c) Facilities and Availability of Plan Providers

For local, in-person counseling, the Plan Provider's offices are located close to where you work or live, and appointments may be available during normal business hours. Some Plan Providers are also available evenings and weekends. To find out the exact address or availability of a Plan

Provider, contact **(800) 344-4222**. The Plan does not guarantee the initial or continued availability of any particular Plan Provider.

(d) Scheduling Appointments

You must call the Plan directly to schedule an initial appointment with a Plan Provider. If you require additional care after the initial appointment, your Plan Provider will arrange for such care. If you cannot keep your scheduled appointment, you are required to notify the Plan Provider or the Plan at least 24 hours in advance of the appointment. You may be assessed one Visit against the counseling benefit for appointments that are cancelled or rescheduled with less than 24 hours' notice, except under circumstances beyond your control (e.g., technical issues related to video counseling).

You can be matched to a Plan Provider through the Plan's Digital Platform. You can get the authorization, then contact the Provider directly to set up an appointment or call the Plan for help with connecting to the recommended Plan Provider. If you choose virtual counseling, then you can choose the telehealth provider you wish to see from the Digital Platform, and schedule your appointment online.

(e) Referrals for Non-Covered Services

If the Plan Provider determines that you require non-Covered Services, your Plan Provider will refer you to an appropriate health care provider or community resource and you will be responsible for the cost of services. Treatment at hospitals or other facilities is not a covered benefit under the EAP.

(f) Changing Plan Providers

You may transfer to another Plan Provider by contacting the Plan by telephone at **(800) 344-4222** and requesting a change.

(g) Service Area

The Plan provides or arranges for the provision of Covered Services, nationwide. If you require Covered Services and want an in-person Plan Provider, please contact the Plan and you will be advised of the closest Plan Provider from your work or home who will provide the care you require. Every attempt will be made to offer referrals to providers who are generally within a 15-20 mile radius. While this may be possible in urban areas, in rural areas the Plan will match Clients to providers who offer telehealth counseling and may try to locate in-person Providers within a 50-mile radius of Client's home or primary work location. Virtual counseling is more convenient, and just as effective as in-person counseling.

(h) Plan Provider Compensation

The Plan compensates its Plan Providers on what is called a Fee for Service basis. The Plan's Providers are always required by the Plan to provide high quality services in accordance with detailed regulatory and contractual requirements.

3. CRISIS INTERVENTION AND URGENT SERVICES

(a) Crisis Intervention:

The Plan arranges for the provision of Crisis Intervention 24 hours a day, seven days a week, to all Clients. You must contact **(800) 344-4222** so the Plan can 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, Psychiatric 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.

(b) Urgent Services:

Clients 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 Client will be referred to a Plan Provider so that care is provided within 24 to 48 hours in Urgent cases.

(c) Medical Emergency Care:

If it is determined by intake clinician, or a Plan Provider or the Client feels the situation constitutes a Medical Emergency Condition or Psychiatric Medical Emergency Condition, the Client will be referred to the nearest hospital emergency room (or trauma center), or told to immediately call the 911 operator for emergency assistance. **Medical Emergency Care is non-Covered Service.** The Plan does not pay for Medical Emergency Care but a Plan Provider can assist the Client in accessing Medical Emergency Care services.

4. FEES

Clients have no obligation to pay for Covered Services provided by the Plan. Your Employer pays the premium for all the Covered Services.

5. OTHER CHARGES

There are no co-pays, co-insurance, or deductibles, and you will not be liable under any circumstances to a Plan Provider for any fees covered by your EAP services in the event the Plan fails to pay the Provider. But, if you desire additional services not covered by the EAP or wish to use more visits than allowed under the plan, or choose a Provider who is not part of the Plan's network, you will be responsible for those payments.

6. REIMBURSEMENT PROVISIONS

Covered Services are provided by the Plan at no cost to you. In the event that a Plan Provider, or a non-Plan Provider who has been authorized by the Plan to provide Covered Services, charges a Client for Covered Services and the Client has paid the provider, they will be reimbursed by the Plan. For reimbursement, contact the Plan at **(800) 344-4222**.

7. DETAILED DESCRIPTION OF COVERED SERVICES

(a) A list of Covered Services is set forth in the Benefit Schedule. See Attachment A. Descriptions of Covered Services that are not covered are set forth in the Exclusion and Limitations Section. As a Client, you may also contact the Plan at **(800) 344-4222** to find out if a particular service is or is not covered.

(b) The Plan provides an EAP Assessment, short-term counseling and referrals to community resources. The Plan provides a problem-focused form of individual or family outpatient counseling, in-person or virtually, that (i) seeks resolution of problems in living rather than basic character changes, (ii) emphasizes the Client'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 Client to practice behavior outside the counseling Visits to promote therapeutic goals.

(c) A Client is entitled to a defined number of Visits with a Plan Provider or Virtual Counseling Partner's provider, as set forth in the Benefit Schedule.

(d) All requests for Covered Services that involve an EAP Assessment and referral are approved. The Plan provides access to all Clients to be assessed and referred to appropriate resources as necessary. When a Client requests a non-Covered Service, the Plan's Clinician will assess the need and discuss the scope of Covered Services and non-Covered Services. The Plan's Clinician will recommend that the Client seek care from an appropriate community resource if the request is for a non-Covered Service.

(e) 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 Client, Plan Providers, and the public upon request by calling **(800) 344-4222**.

8. LIMITATIONS

(a) General Limitations:

(i) Unless otherwise authorized by the Plan, all Covered Services must be performed by a Plan Provider or BetterHelp Provider

(ii) The number of Visits is limited, as set forth in the Benefit Schedule.

(b) Video Counseling Limitations:

(i) Video counseling requires high-speed internet and proper audio and video equipment.

(ii) The Client seeking video counseling must receive the counseling from a Plan Provider or BetterHelp Provider licensed in their State.

(iii) The video counseling platform is limited to three (3) separate connections, in addition to the Plan Provider's connection, for group counseling (e.g., couples and families).

(iv) Video counseling is not available in the following situations:

(1) There are expressed or perceived, imminent or foreseeable safety risks at the time video counseling is requested or during the course of video counseling; or

(2) It is apparent that active alcohol or drug abuse is a relevant concern.

(v) Plan Providers may decline to provide video counseling at any time if they determines that video counseling is inappropriate for the Client.

9. EXCLUSIONS

The following services are specifically excluded from the Licensed EAP Services provided under this Group Agreement:

a. Emergency Medical Care services and treatment

b. Acupuncture

c. Aversion therapy

d. Biofeedback and hypnotherapy

e. Services required by court order, or as a condition of parole or probation, not, however, to the exclusion of services to which the Client would otherwise be entitled

f. Services for remedial education including evaluation or treatment of learning disabilities or minimal brain dysfunction, developmental and learning disorders, behavioral training, or cognitive rehabilitation

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

h. Experimental or investigational procedures

i. Services for medical treatment of mental retardation or defects and deficiencies of functional nervous disorders, including chronic mental illness

j. Services received from a non-Plan Provider, unless the Plan provides prior approval

k. 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 or Emergency Medical Care for non-Covered Services)

l. Sleep therapy

m. 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

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

o. Medical treatment of speech and hearing impairments (A speech or hearing impaired Client 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 or Emergency Medical Care for non-Covered Services)

p. IQ testing (IQ testing is not necessary to determine appropriate referral to a Plan Provider to receive Covered Services, or alternatively, to determine appropriate referral to community resources or Emergency Medical Care for non-Covered Services)

q. Medical treatment for chronic pain

r. Services involving medication management or medication consultation with a psychiatrist

10. GENERAL INFORMATION

(a) When Does Coverage Begin (Commencement of Coverage)

Coverage begins on the first day that the Subscriber becomes an Employee of the Group and meets any additional eligibility requirements as established by the Employer. Coverage of Covered Dependents begins at the same time.

(b) Notifying Clients of Changes to the Plan

If your Covered Services change during the time you are covered, the Plan, through your Employer, will notify you of the change within 60 days of the effective date of any change.

(c) Family Health Insurance Notification

A non-custodial parent of a Covered Dependent child is entitled to inspect the child's Plan membership, Combined Evidence of Coverage 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.

(d) Confidentiality of Information

The Plan abides by federal and state mandates governing confidentiality. All information pertaining to your identity, medical diagnosis or treatment that the Plan may possess as a result of care provided by any provider will be kept confidential and will not be disclosed to any person and your Employer, without your prior written consent unless permitted or required by law. The Plan's Privacy Policy is available on the Plan's Website. You may also request it at **(800) 344-4222.**

(e) Requesting Your Medical Records and Confidential Communications

You have a right to access your medical records under California law, including for services received via a telehealth provider. You may request that all communication regarding you receiving sensitive services be kept confidential by having them sent to an alternative address, phone number, or email. You may also request the Plan to send certain communications to you in a particular form and format, such as communications containing your Medical Information (as defined under Important Terms below) and/or your provider's name and address.

To make a request, contact the Plan via email at info@concernhealth.com, or by mail at 2490 Hospital Drive, Suite #310, Mountain View, California 94040, or by telephone 800-344-4222.

The Plan will comply with that request if the form and format is readily producible. Your request shall remain valid until you revoke the request or submit a new request. The Plan shall implement your request within seven (7) calendar days of receiving it electronically or within fourteen (14) calendar days

of receiving it by first-class mail. The Plan will acknowledge receiving your request and let you know the status of implementing such a request.

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

11. TERMINATION OF BENEFITS

(a) Your coverage may terminate for any of the following reasons:

(i) You are no longer employed by or meet the eligibility requirements of the Group. Coverage for you and all Covered Dependents will end at 11:59 p.m. on the last day of the month in which your employment or eligibility for coverage ends.

(ii) You no longer qualify as a Covered Dependent. Coverage will end at 11:59 p.m. on the last day of the month in which you no longer qualify as a Covered Dependent.

(iii) You commit fraud or deception in the use of Covered Services, or knowingly permit such fraud or deception of another. Coverage will end thirty (30) days from the date the notice is mailed to you.

(iv) The Agreement for Employee Assistance Services (the "Agreement") is terminated by either the Group or the Plan:

- The Group voluntarily terminates the Agreement. Coverage will end as provided for in the Agreement.

- The Group commits fraud or makes an intentional misrepresentation of material fact under the terms of the Agreement. Coverage will end as provided for in the Agreement.

- The Group fails to pay Fees. The Plan will provide the Group with a sixty (60) day grace period that begins on the first day after the last date of paid coverage to make payment of overdue Fees to the Plan. During the grace period, coverage will continue. If the Group does not make payment to the Plan by the end of the grace period, coverage will end at 11:59 p.m. on the last day of the grace period.

(b) Coverage will not be terminated due to a Client's health status or requirements or need for Covered Services. If you think this has happened, you may request a review by the California Department of Managed Health Care (DMHC or Department) by calling the toll-free number (888) HMO-2219 or (888) 466-2219.

12. RENEWAL PROVISION

This Plan automatically renews on the anniversary date of the Agreement, or per the contract/renewal term unless notice of termination is served within the time specified or as otherwise provided in the Agreement. However, the Plan may increase the amount paid by the Group, or decrease the benefits stated in the Agreement, by providing sufficient written notice of such changes prior to the renewal date. If the Agreement is terminated or not renewed, your Group shall notify you thirty (30) days prior to the termination date.

13. COMPLAINTS AND GRIEVANCES

(i) Grievances

The Plan has established a Grievance process for receiving and resolving Client complaints ("Grievances") with the Plan or its contracted Providers. If any Client has any problem with any services delivered through the Plan, the Plan's Clinical Manager or Director of Clinical Services shall be responsible for receiving and resolving those problems.

Grievance procedures are communicated to Clients at the time of enrollment and annually thereafter by way of this Combined EOC/DF. A summary of the grievance process is provided on a Client Grievance form, which can be accessed online at **www.concernhealth.com**. At the time of the initial counseling visit, the Client is provided with information regarding grievance procedure, including phone number and email. A copy of the grievance form as well as information about the grievance process is included in the Provider Portal. Under the Grievance process:

(1) The Plan's Clinical Manager or Director of Clinical Services shall review any complaint involving Licensed EAP Services provided to the Client, or if applicable, denied to the Client and in the case of a denial;

(2) Clients may submit a Grievance by:

a. Telephone: Call our toll-free number at 1-800-344-4222;

b. Fax: (650) 961-5737;

c. E-mail: info@concernhealth.com;

d. Online: www.concernhealth.com; or

e. Mail:

Attn. Clinical Manager
CONCERN: Employee Assistance Program
2490 Hospital Drive #310
Mountain View, CA 94040

Grievances received via e-mail, fax, mail, or from the CONCERN: EAP website are monitored daily by designated staff. The grievance is immediately forwarded to the Clinical Manager who then follows the same procedures as outlined above.

(3) The Plan's Clinical Manager or Director of Clinical Services shall advise Clients that the Plan will acknowledge receipt of Grievances in writing within five (5) calendar days and will provide written resolution of the Grievance within thirty (30) calendar days of the Plan's initial receipt of such Grievance; and

(4) If a Grievance requires urgent attention, the Plan's Clinical Manager or Director of Clinical Services will resolve urgent the Grievance within 48 business hours.

(ii) Review by the Department of Managed Health Care

(a) The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a Grievance against your health plan, you should first telephone your health plan at **(800) 344-4222** 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 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 **(888) 466-2219** and a TDD line **(877) 688-9891** for the hearing and speech impaired. The Department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

(b) Urgent Grievances: If you are experiencing an imminent and serious threat to your health, including but not limited to, severe pain, potential loss of life, limb, or major bodily function (an "Urgent Grievance"), the Plan will inform you at the time the Urgent Grievance is lodged that you may immediately contact the Department of Managed Health Care. The Plan will also provide you and the Department of Managed Health Care with a written statement on the disposition or pending status of such grievances no later than three (3) calendar days from receipt of the Urgent Grievance.

(c) Non-Discrimination: At no time will the Plan discriminate against a Client on the grounds that the Client filed a grievance against the Plan or Plan Provider. If you feel that services have been denied or modified because you filed a grievance, you can contact the Quality Assurance Clinical Manager for the Plan at **(800) 344-4222** for review.

Concern offers free language assistance to Clients whose primary language is not English. You can request an interpreter at no cost to speak to Concern or a counselor. To request an interpreter or ask about written information in your language, first call Concern at (800) 344-4222. Someone who speaks your language can help you. If you need more help, call the HMO Help Center at 888-466-2219.

Puede solicitar un intérprete sin cargo para hablar con Concern o un asesor. Para solicitar un intérprete o información escrita en su idioma, primero llame a Concern al 800-344-4222. Una persona que hable su idioma puede ayudarlo. Si necesita más ayuda, llame al Centro de Ayuda de HMO al 888-466-2219.

Makakahiling kayo ng isang tagasalin ng wika upang makipag-usap sa Concern o isang tagapayo. Upang humiling ng isang tagasalin ng wika o magtanong tungkol sa nakasulat na impormasyon sa inyong wika, tumawag muna sa Concern sa 800-344-4222. Ang isang nagsasalita ng inyong wika ay makakatulong sa inyo. Kung kailangan ninyo ng karagdagang tulong, tawagan ang HMO Help Center sa 888-466-2219.

在與 Concern （EAP 或者一位輔導員） 聯絡時，您可以請求免費提供口譯人員。如需請求提供口譯人員或以您的語言提供書面資料，請首先致電 Concern，電話號碼是 800-344-4222。 將有一位會講您語言的工作人員幫助您。 如果您需要更多幫助，請致電 HMO 協助服務中心，電話號碼是 888-466-2219。

14. ARBITRATION

Any and all disputes of any kind whatsoever, including, but not limited to, claims for malpractice (that is as to whether any Benefits rendered were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered) between Employer (including any heirs, successors, or assignees of Employer or Clients) and Plan, except for claims subject to ERISA (if applicable), shall be submitted to binding arbitration in California. 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. Group 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.

15. CONTINUITY OF CARE

1. Eligibility

Any newly covered Client with an acute, 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 Client is newly covered under the EAP, Client will be offered the option of continued care with their non-Plan Provider through the EAP, provided Client notifies the Plan no later than forty-five (45) days after effective date of coverage and the non-Plan provider agrees to the Plan's contract terms and rates. The Clinical Director/Manager 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 Client's treatment for the condition. Notification of the referral acceptance and a referral confirmation is sent to the provider. If the provider declines to provide services, Client will be notified in writing.

Continuity of Care is also available for current Clients.

In the event a Plan Provider terminates from the Plan and a Client was receiving Covered Services from such terminated Plan Provider at the time of termination, the Plan will allow the Client to continue to receive such Covered Services from the terminated Plan Provider at the Plan's cost and at no cost to Client until services being rendered are completed, unless the Plan makes reasonable and medically appropriate arrangements to transfer care to a current Plan Provider. If for any other reason the terminated Plan Provider is unavailable or

unable to continue care of the Client, the Plan will make immediate arrangements to transfer care to a current Plan Provider.

2. Access

(i) Client may access the services of the Provider by calling the Plan and indicating to the intake person that they have an ongoing client-patient relationship with the Provider.

(ii) Client then should ask their Provider to connect with and provide information to the Plan, to be added to the Plan's panel. The non-Plan Provider must agree to continue until one of the following occurs:

(a) The episode of care is completed.

(b) Client's Benefits are exhausted, in which case Client will be transitioned to other ongoing care.

(c) Reasonable transition period or reasonable number of transitional visits with non-Plan provider is exhausted.

(d) A reasonable transition period is determined on a case-by-case basis, during which time Client would continue to see the non-Plan Provider. Consideration is given to the severity of Client's condition and the amount of time reasonably necessary to effect a safe transfer with input from the Client and the non-Plan provider as to when it is safe to transition to another Provider, or into the full service health plan. The Clinical Director/Manager will be consulted on these decisions.

(iii) 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 the Client's employer/Member's Group Agreement for EAP with the Plan.

(c) The non-Plan Provider must agree in writing to the same contractual terms as a Plan Provider, which includes payment rates.

(d) Client must be new to Plan.

(iv) The Plan is not liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provision of services by the existing non-Plan provider.

16. INDIVIDUAL CONTINUATION OF BENEFITS

(a) If an Employee terminates his or her employment with the Employer for any reason (including death), the Employee and the Employee's spouse or domestic partner and his or her Covered Dependents are able to receive Covered Services from a Plan Provider from whom they are currently receiving care from, up to the maximum number of Visits to which they are entitled, as set forth in the Benefit Schedule. If an Employee terminates his or her marriage and a court of law grants such divorce by issuing a divorce decree, the Employee's former spouse is able to receive Covered Services from a Plan Provider for whom he or she is currently receiving care from, up to the maximum number of Visits to which he or she is entitled, as set forth in the Benefit Schedule.

(b) Employees and/or their Covered Dependents are entitled to receive Covered Services following the Employee's termination of employment if the Client elects to continue coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA) or California COBRA (Cal-COBRA), as appropriate. Covered Services under COBRA or Cal-COBRA do not include Work/Life services (financial consultations, legal consultations, parenting and childcare resources, adult care resources); these are not ERISA-regulated benefits and are provided for the Employer's convenience by the Plan.

COBRA

If Group's Member is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, Clients may be entitled to continuation of the Group's coverage under the act (COBRA Coverage). Clients may qualify for COBRA Coverage if they lose the Group's coverage due to the occurrence of one of the qualifying events:

- Termination or separation from employment for reasons other than gross misconduct.
- Reduction of work hours.
- Death of the Employee or surviving spouse (as applicable).
- Termination of eligibility of a spouse due to divorce or legal separation.
- Termination of eligibility of a dependent child.
- Covered dependent if Employee becomes eligible for Medicare

COBRA Coverage extends up to thirty-six (36) months, depending on the individual's qualifying event. COBRA Coverage may be terminated on the occurrence of certain events. The Group is responsible for providing Clients with notice of their right to receive COBRA Coverage, eligibility and payment requirements. Group will provide Clients with complete information on COBRA qualifying events, COBRA Coverage termination circumstances, and ineligibility for COBRA Coverage.

Individual must provide Member (Employer), 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 individual must make payment of periodic fees within forty-five (45) days of such written request. Individuals whose continuation of coverage under COBRA will expire may be eligible for continuation of coverage under Cal-COBRA.

Cal-COBRA

If an individual is subject to the California Continuation Benefits Replacement Act (Cal-COBRA), they may be entitled to continuation of Group's coverage under that act (Cal-COBRA Coverage). Group is subject to Cal-COBRA continuation coverage if its Client: 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 Client is subject to Cal-COBRA, Employees or their dependents may qualify for Cal-COBRA if they 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 Employee or surviving spouse (as applicable). .
- Termination of eligibility of a spouse due to divorce or legal separation.
- Termination of eligibility of a dependent child.
- Covered dependent if Employee is entitled to Medicare.
- Employee whose COBRA coverage will expire.

Cal-COBRA Coverage extends for up to thirty-six (36) months from the qualifying event unless terminated earlier by the occurrence of certain events. See EOC/DF for additional information regarding Cal-COBRA coverage. The Group is responsible for providing Clients with notice of their right to receive Cal-COBRA Coverage, eligibility and payment requirements. Covered Services under COBRA or Cal-Cobra do not include Work-Life services (parenting and childcare resources, adult care resources, financial services, or legal consultations); these are not ERISA-regulated benefits and are provided for the Group's convenience by the Plan. Covered Services under this Group Agreement are specified in detail in ATTACHMENT A entitled "COVERED SERVICES", which is attached hereto and incorporated herein.

Individual 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 individuals must make payment of Periodic Fees within forty-five (45) days of such written request.

Group's Members must notify Plan within thirty (30) days of a termination of employment or reduction in work hours of Employee, which would result in ending coverage under the Employee's benefit plan. Failure to notify Plan within sixty (60) days of the occurrence of a qualifying event will disqualify the Employee from receiving continuation of coverage. Notifications of a qualifying event are generally made to Group's Member, or Group's COBRA administrator.

Within fourteen (14) days of receiving notification of a qualifying event, the Group, or Group's COBRA administrator, will send enrollment and Premium information, including a Cal-COBRA Election Form. Clients 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 Clients were sent the Cal-COBRA enrollment and Premium information.

Client's Cal-COBRA Premium payment must be received within forty-five (45) days of the date the Client's Cal-COBRA Election Form was received. Failure to send the correct Premium amount with forty-five (45) days will disqualify Client from continuation coverage under Cal-COBRA. The first Premium payment equals the amount of all Premiums due from the first month following the qualifying event through the current month. After the initial payment, Cal-COBRA Premiums are due on the first day of each month. The Cal-COBRA Premium is generally 110% of the Premium charged to Group Members for Employees. Individual's enrollment in Cal-COBRA will not occur until both Cal-COBRA Election Form and first Cal COBRA Premium payment have been received.

Usually, a Client'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 health plan not maintained by the employer or any other health plan, regardless of whether that coverage is less valuable. Client's Cal-COBRA continuation coverage may terminate early if: individual moves out of Plan's service area; individual does not pay the required Premium within fifteen (15) days of it being due; individual commits fraud or deception in using Plan's services; individual obtains other coverage.

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

17. PUBLIC POLICY PARTICIPATION

The Plan seeks applicants who would be interested in participating in the Public Policy Committee for the purposes of establishing the public policy of the Plan.

The Public Policy Committee reviews the Plan's performance and future direction of Plan operations. Information regarding Plan operations, grievance log reports, financial operations and the like will be made available to Clients for review and comment. When applicable, recommendations and reports from the Public Policy Committee will be forwarded to the Plan's Board of Directors. If you would like to participate in the Plan's Public Policy Committee, please contact 1-800-344-4222.

18. DEFINITIONS

This document uses the following defined terms:

A. **AGREEMENT** means the Agreement for Employee Assistance Services between the Plan and the Group or Employer, this Evidence of Coverage and any addenda and/or amendments thereto.

B. **BENEFITS** means those Licensed EAP Services an Employee or Client is entitled to receive under the Agreement.

C. **BENEFIT PERIOD** means the period of time during which the Benefits are available to Clients under this Agreement.

D. **COMBINED EVIDENCE OF COVERAGE/DISCLOSURE FORM (EOC/DF)** is a document issued to a Group and provided by the Group via its Members to the Clients, setting forth the coverage to which the Employee or Client is entitled.

E. **CO-PAYMENT** means the amount, if any specified herein, which represents the Employee/Client's portion of the cost of Covered Services. There are no Co-Payments required of any Client in the program covered by this Group Agreement.

F. **COVERED SERVICES** means the Benefits available to Employees and their eligible dependents under the Agreement.

G. **COVERED DEPENDENT** means the Employee's (1) spouse; (2) domestic partner, as defined by California Family Code Section 297; (3) child up to age twenty-six (26) years of age, including biological, adopted, step-children or court-ordered dependents; or (4) child over twenty-six (26) years of age who are incapable of self-sustaining employment by reason of mental or physical disability and chiefly dependent upon the Employee for support and maintenance. A former spouse or former domestic partner is not a Covered Dependent.

H. **CRISIS** is the perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms and that has the potential to cause behavioral and cognitive malfunction. It is a situation where there is an immediate need to assess for possibility of a medical emergency condition, psychiatric emergency condition or to request services from the Plan relating to an urgent situation.

I. **CRISIS INTERVENTION** means the process of responding to a request for immediate services in order to determine whether or not a medical-psychiatric emergency or urgent situation exists and to otherwise assess the needs for short-term counseling, referrals to community resources and/or referrals to medical psychiatric services.

J. **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 to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

K. **EMERGENCY SERVICES** includes medical screening, examination and evaluation by a physician, or other appropriate Providers under the supervision of a physician to determine if an Emergency Medical Condition exists, and if it does, the care, treatments, and surgery by a physician necessary to relieve or eliminate the Emergency Medical Condition. Emergency Services also include screening, examination and evaluation by an MD psychiatrist, physician or other applicable Providers within the scope of their licenses to determine if a psychiatric medical condition exists and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition.

L. **EMPLOYEE ASSISTANCE PROGRAM ASSESSMENT** means the process of determining, based on information provided by a Client, the need for either: (1) short-term counseling; (2) referral(s) to community resources; or (3) referral(s) to medical emergency care services or treatment.

M. **EMPLOYEE ASSISTANCE PROGRAM 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.

N. **ENROLLEE/EMPLOYEE/CLIENT** means a person who is enrolled in the Plan or who is a recipient of services from the Plan – maybe full-time salaried or hourly employees who are actively at work at least 30 hours per week, part-time employee working a minimum of 20 or more hours per week or other eligible employees, and/or dependent, or retiree as defined by the Group's Members. Client is an Employee or eligible family member of such Employee, in each case who is an eligible recipient of services from the Plan and are referred to as "Clients" for purposes of the Act and the Rules.

O. **EXCLUSIONS** means services that are not covered under this Agreement.

P. **GRIEVANCE** means a written or oral expression of dissatisfaction regarding the Plan and/or Provider, including quality of care concerns, and shall include a complaint, dispute, or request for reconsideration or appeal made by a Client or the Client's representative. Where the Plan is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

Q. **PLAN PROVIDER** means clinical psychologist (PhD), licensed clinical social worker (LCSW), marriage family and child therapist (MFT), or certified addictions counselor (CAC) who are contracted with the Plan to provide covered services including assessment, referral or short-term counseling services to Client under the Plan.

R. **PROVIDER** means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

S. **PSYCHIATRIC MEDICAL EMERGENCY CONDITION** means a mental disorder that manifests as acute symptoms of sufficient severity that it renders the Client as being either of the following:

a. An immediate danger to himself or herself or to others

b. Immediately unable to provide for, or utilize food, shelter or clothing due to the mental disorder

T. **SESSION** means an outpatient **VISIT** by an Employee or Client with a Provider conducted on an individual basis lasting 45-50 minutes, during which counseling services are delivered to such a person.

U. **URGENT** means a situation in which it is determined that no medical emergency exists, however, the Employee/Client is in need of immediate telephone support and/or an appointment with a Plan Provider within 24-48 hours to resolve a serious problem or condition.

CONCERN NOTICE OF PRIVACY PRACTICES

Effective July 1, 2017; rev: May 6, 2021

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

About This Notice

We understand that information about you is personal, and we are committed to protecting your privacy. In the normal course of business, we collect information and create records about you and the services we provide to you. We may collect information from other persons or entities, such as employers or health care providers, to provide our services to you. For example, we may collect enrollment information from your employer to determine eligibility for our services. The information that we collect and create about you includes Protected Health Information.

Protected Health Information is information that could be used to identify you, and relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice, and we are prohibited from any disclosure of Protected Health Information beyond the provisions of the law.

How We Protect Your Privacy

To protect your privacy, we maintain physical, technical, and administrative safeguards. For example, only employees who are authorized and trained to handle Protected Health Information are given access to such information. Some other examples include password-protecting computers and locking filing cabinets that contain personal information.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information without your authorization in the following circumstances:

For Treatment: We may use your Protected Health Information to provide you with treatment or services and to manage and coordinate your medical care. We may also disclose your Protected Health Information for purposes of diagnosis and treatment to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians. For example, we may share the problem that you wish to resolve with a provider to ensure an appropriate referral.

For Payment: We may use and disclose your Protected Health Information to obtain payment of premiums for your coverage and to pay providers for the covered services you receive. We may also use and disclose your Protected Health Information to make coverage determinations or to otherwise determine and fulfill our responsibility to provide benefits. For example, if you are covered by another health plan, we may use or disclose your Protected Health Information to the other health plan to coordinate benefits.

For Health Care Operations: We may use and disclose Protected Health Information for our health care operations. For example, we may use Protected Health Information for our general business management activities, for checking on the performance of our providers in caring for you, for our cost-management activities, for audits, or to get legal services. We may disclose Protected Health Information to other health care entities for purposes of reviewing provider competence and qualifications or the medical necessity, level of care, quality of care, or justification of charges of health care services.

Communications: We may use and disclose Protected Health Information to contact you with information about alternative treatments or health-related benefits and services, or to remind you that you have an appointment for care.

Minors: We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Personal Representative: If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your Protected Health Information.

As Required by Law: We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

Business Associates: We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide other services for us. All of our business associates are obligated, under contract with us, to also protect the privacy of your Protected Health Information.

Military: If you are a member of the armed forces, we may use and disclose your Protected Health Information for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. We also may release Protected Health Information to the appropriate foreign military authority if you are foreign military.

Workers' Compensation: We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report the abuse or neglect of a child, elder, or dependent adult; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities: We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Employment-Related Health Care Services: We may disclose your Protected Health Information to your employer if the information was created as a result of employment-related health care services provided to you at the specific prior written request and expense of your employer, and it: (1) is relevant to and will be used only in a lawsuit, arbitration, grievance, or other claim or challenge to which you and your employer are parties and in which you have placed your medical history, condition, or treatment at issue; or (2) describes your functional limitations that may entitle you to leave work for medical reasons or limit your fitness to perform your present employment, provided that no statement of medical cause is disclosed.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves if you sue us.

Law Enforcement: We may release Protected Health Information if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security: We may release Protected Health Information to authorized federal officials for national security activities authorized by law. For example, we may disclose Protected Health Information to those officials so they may protect the President.

Coroners, Medical Examiners, and Funeral Directors: We may release Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties. For example, disclosure of Protected Health Information may be necessary to identify a deceased person or determine cause of death.

Organ Donations: We may release Protected Health Information to organ-procurement organizations or tissue banks, as necessary to assist with organ or tissue donation.

Research: Under certain circumstances, we may use and disclose your Protected Health Information for research purposes, provided certain measures are taken to protect your privacy.

<u>Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out</u>
Individuals Involved in Your Care or Payment for Your Care: We may disclose Protected Health Information to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. But before we do so, we will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so.

Disaster Relief: We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of

your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Fundraising: We do not use or disclose Protected Health Information for fundraising purposes, but we are required to inform you that you would have the right to opt out of receiving fund-raising communications.

Your Written Authorization is Required for Other Uses and Disclosures:

Your written authorization is required for:

- Disclosures of any Protected Health Information for marketing purposes and disclosures that constitute the sale of Protected Health Information.
- Use and disclosure of "therapy notes" that are maintained by us, except under certain circumstances. For example, we may use or disclose therapy notes without your authorization to defend ourselves in a legal action or other proceeding initiated by you.
- Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these kinds of Protected Health Information. Please check with our Privacy Officer for information about the special protections that do apply.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

Right to Inspect and Copy: You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records: If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Security Breach: We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breach of your Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days

after we discover the breach. “Unsecured Protected Health Information” is Protected Health Information that has not been made unusable, unreadable, and undecipherable to unauthorized users. The notice will give you the following information:

- a short description of what happened, the date of the breach and the date it was discovered;
- the steps you should take to protect yourself from potential harm from the breach;
- the steps we are taking to investigate the breach, mitigate losses, and protect against further breaches; and
- contact information where you can ask questions and get additional information.

If the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach in a major print or broadcast media.

Right to Request Amendments: If you feel that Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the end of this Notice and it must tell us the reason for your request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) is not information that you would be permitted to inspect and copy, or (4) is accurate and complete. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures: You have the right to ask for an “accounting of disclosures,” which is a list of the disclosures we made of your Protected Health Information. We are <u>not</u> required to list certain disclosures, including (1) disclosures made for treatment, payment, and health care operations purposes, (unless the disclosures were made through an electronic medical record, in which case you have the right to request an accounting of those disclosures that were made during the 3 years before your request), (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. Your request should indicate in what form you would like the accounting (for example, on paper or by e-mail). The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments: If you paid out-of-pocket in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications: You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the end of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer at the phone number or address listed at the end of this Notice.

Changes to This Notice

The effective date of the Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services.

To file a complaint with us, contact our Privacy Officer at the address listed below. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

Foreign Language Version

If you have difficulty reading or understanding English, you may request a copy of this Notice in you preferred language.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICE: Concern Privacy Office, 2490 Hospital Drive, Suite 310; Mountain View, CA 94040; (800) 344-4222.

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 Employee of the Group's Members and their Covered Dependents shall be limited to a maximum of **Three (3) Visits** each problem per twelve-month period, beginning with the date of the case opening. For the purpose of this provision, the word "problem" means a specific type of matter, situation or issue of concern to a Client for which the Client requests EAP services for purposes of obtaining assistance in arriving at a solution. If an Employee is referred for unsatisfactory work performance by means of a Supervisor Referral, or if an Employee or Covered Dependent is assessed as having a chemical dependency problem, the maximum number of visits shall be Ten (10) irrespective of the counseling model chosen. The Plan provides counseling for "problem" issues including but not limited to:

   (i) marital and family problems

   (ii) difficulty with relationships

   (iii) emotional distress

   (iv) job stress

   (v) communications or conflict issues

   (vi) substance abuse issues

   (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 Client's skills, strengths and resources

   (iii) involves setting and maintaining realistic goals that are achievable in a one to five month period

   (iv) encourages the Client to practice behavior outside the counseling Visits to promote therapeutic goals

C. The Plan can also refer Client to vetted resources and services for financial, legal, parenting and childcare, and adult care issues.

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

E. A Plan Provider will also refer a Client to community resources for assistance for non-Covered Services. In the event of such referral, the Client shall be advised by The Plan and

the Plan Provider that the Client is responsible for payment of costs and fees for services provided.

Term: July 1, 2023 through June 30, 2026	
Eligibility	Employee, spouse or domestic partner, dependents up to age 26
24/7 access: Clinical First Intake Center and Self-Serve Digital Platform	Immediate access to licensed clinicians who answer intake calls and guide callers to the right support right from the start, providing triage and In-the-Moment support as needed. Or access via our Plan's Digital Platform for a personalized care plan and counselor matching
Short-term Counseling – 3 Visits	Confidential, evidence-based counseling to help employees and their family members build coping skills for real-world issues. Multiple counseling options: video, in-person, phone, live chat and text, allows Clients to find options that fit their preferences
In-the-moment clinical support	For triage, emotional support, problem-solving, positive next steps
Parent Coaching – 3 telephone sessions	Online coaching with an experienced professional for parents to get help with their child's emotional wellbeing
Alcohol or substance use – 10 Visits	Elevated to 10 visits at no additional charge for chemical dependency issues
Work-Life Resources	Practical guidance and solutions for life events including • Financial Consultations (planning, budgets, credit, home-buying; two 30-min consultations with a financial expert) • Legal Consultations (up to 30 minutes with an attorney, discounted fees when you engage the attorney) • Parenting & Childcare Resources (daycare, schools, adoption, prenatal), complimentary New Baby kit • Adult Care Resources (housing alternatives, services) • ID-Theft
Guided Mindfulness Solutions	Fully integrated suite of live and on-demand evidence-based mindfulness solutions personalized for physical and emotional wellbeing
Digital Self-Help Library	Curated self-help resources to engage, educate, and empower users to build emotional wellbeing

SUMMARY PLAN DESCRIPTION

It is intended that the information outlined below will meet the "Summary Plan Description" requirements of the Employee Retirement Income Security Act (ERISA).

Plan Name:	Superior Court of California - County of Santa Barbara Employee Assistance Program
Name & Address of Employer Sponsoring the Plan:	Superior Court of California - County of Santa Barbara 118 East Figueroa Santa Barbara, CA 93101
Employer's I.D. Number:	77-0559062
Type of Plan:	The Plan described in this Summary Plan Description is a "Welfare Benefit Plan" for the purposes of ERISA.
Plan Administrator & Tel. No.:	CONCERN: EAP 1-800-344-4222
Where Legal Process May be Served:	Superior Court of California - County of Santa Barbara 118 East Figueroa Santa Barbara, CA 93101
Insurance Contracts & Policy Nos.:	Employee Assistance Program Organization No. 89293
Sources of Contributions to the Plan:	The Plan is funded by contributions from the employer.
Plan Year:	The financial records of this Plan are kept on a Plan Year basis. The Plan Year begins July 1, 2023.
Plan Details:	This Plan's provisions relating to eligibility to participate and termination of eligibility as well as a description of the benefits provided by this Plan are described in detail in the Covered Person's Evidence of Coverage which directly precedes this ERISA information.