CONCERN: Employee **A**ssistance **P**rogram

Introduction to
CONCERN: Employee Assistance Program
Combined Evidence of Coverage and Disclosure Form (EOC)

The purpose of the EOC is to provide you with a summary of the contract between LifeLong Medical Care ("the Group") and CONCERN: Employee Assistance Program ("Concern" or "the Plan") and the services offered to its Employees. Some of the highlights are:

ELIGIBILITY:

If you are an Employee of the Group who works or resides in the Plan's service area, and meets any additional eligibility requirements as established by the Group, or a Covered Dependent of an Employee, you are automatically enrolled in the Plan. No enrollment is necessary.

EMPLOYEE SERVICES:

Digital Platform, a digital guide to customized care recommendations.

Short-term counseling, up to Six (6) Visits per problem per year, for:
- Relationship issues (e.g., families, couples, parent/child)
- Emotional issues (e.g., stress, depression, anxiety, grief, loss, death)

Short-term counseling, up to Ten (10) Visits per problem per year, for problems with:
- Substance abuse issues (alcohol, drugs)

Work/Life Services - Information and Referrals for:
- Parenting & Childcare Resources (daycare, schools, adoption, prenatal)
- Adult Care Resources (housing alternatives, services)
- Legal Consultations (up to 30 minutes with an attorney)
- Financial Services (budgets, credit, home-buying)

LANGUAGE ASSISTANCE:

You can request an interpreter at no cost to speak with 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。

The following Combined Evidence of Coverage and Disclosure Form gives you the details you need to know about specific services, their limits and exclusions, procedures to obtain benefits, appeals and other aspects of your organization's contract with Concern.

CONCERN: Employee Assistance Program

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM (EOC)

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

FOR

LifeLong Medical Care

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

THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM 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. FOR FURTHER INFORMATION ABOUT THE BENEFITS THAT YOU ARE ENTITLED TO RECEIVE, PLEASE CONTACT EITHER CONCERN: EMPLOYEE ASSISTANCE PROGRAM AT (800) 344-4222 OR THE GROUP 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 CAREFULLY AND INDIVIDUALS WITH SPECIAL NEEDS SHOULD READ CAREFULLY THOSE SECTIONS THAT APPLY TO THEM.

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1. INTRODUCTION TO THE PLAN

CONCERN: Employee Assistance Program ("the Plan") is a prepaid employee assistance plan. The Plan provides assistance to businesses and public organizations in the design, implementation, and maintenance of employee assistance programs for the personnel (and their spouses, children and domestic partners) of such businesses and public organizations. The Plan has a panel of Plan Providers from whom to select. All of the services performed by Plan Providers are covered at no cost to you as a Member.

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 communications regarding your receipt of sensitive services be kept confidential by having them sent to an alternative address, phone number, or email. You may also request the Plan 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 online at www.concernhealth.com/contact-us/, 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.

Telehealth

You may receive Covered Services on an in-person basis or via telehealth from a Plan Provider. 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 assessed towards your available number of Visits. If you are currently receiving telehealth services from a Provider, you have the option of continuing to receive that service with your current Provider so long as your Provider remains contracted with the Plan to provide those services to you.

2. DEFINITIONS

This document uses the following defined terms:

(a) "**AGREEMENT FOR EMPLOYEE ASSISTANCE SERVICES**" **or** "**AGREEMENT**" means the agreement between the Plan and the Group for Covered Services.

(b) **"COVERED DEPENDENT"** means the Subscriber's spouse or domestic partner, Subscriber's biological child, Subscriber's adopted child or step-child, or domestic partner's biological or adopted child. (Coverage for adopted children of a Subscriber or domestic partner 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 or domestic partner 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 or domestic partner's right to control the health care of the child placed for adoption.) The Plan shall not deny enrollment of a Subscriber's child or a Subscriber's domestic partner'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. Dependent children are covered under the age of 26. Dependent children who are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and who are chiefly dependent upon the Subscriber for support and maintenance, are eligible for continuing membership in the Plan.

(c) "**COVERED SERVICES**" means the services, which are provided by the Plan to Members and set forth in section 24 of this EOC.

(d) "**CRISIS**" means a situation wherein a reasonable person determines there is an immediate need to assess for the possibility of a Medical Emergency Condition, Psychiatric Medical Emergency Condition, or to request services from the Plan relating to an Urgent situation.

(e) "**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.

(f) **"EAP ASSESSMENT**" means the process of determining, based upon information provided by a Member, the need for either:

(i) short term counseling,

(ii) referral(s) to community resources,

(iii) referral to Medical Emergency Care.

(g) "**EMPLOYEE**" means a full-time or regular part-time employee working 20 hours per week, as defined by the Group.

(h) **"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, request for reconsideration or appeal made by a Member or the Member's representative. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. Grievances may be communicated to the Plan via telephone, FAX, e-mail, on-line through the Plan's website, or submission of a written grievance form.

(i) **"GROUP" or "THE GROUP"** means the entity that has entered into the Agreement for Employee Assistance Services, which requires the employer to pay the entire Prepayment Fee due in order for Members to receive Covered Services.

(j) **"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 birthing 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.

(k) **"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 reasonably be expected to result in any of the following:

(i) Placing the patient's health in serious jeopardy.

(ii) Serious impairment to bodily functions.

(iii) Serious dysfunction of any bodily organ or part.

(l) "**MEMBER**" means a person who is enrolled in the Plan and eligible to receive Covered Services. Member includes the Subscriber and any Covered Dependents.

(m) **"PLAN" or "THE PLAN"** means CONCERN: Employee Assistance Program.

(n) **"PLAN PROVIDER"** means a person who has entered into a Plan Provider contract with the Plan to provide Covered Services to Members, and who is licensed in the State they practice in as either a psychologist, clinical social worker, or marriage and family therapist.

(o) **"PREPAYMENT FEES"** means the periodic fees that the Group agrees to pay the Plan in advance for Covered Services.

(p) **"PSYCHIATRIC MEDICAL EMERGENCY CONDITION"** means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

(i) An immediate danger to himself or herself or to others.

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

(q) **"SERIOUS PERSONAL PROBLEM"** means a circumstance wherein a Member believes he or she requires Covered Services to resolve a Crisis, important, or complex matter.

(r) **"SUBSCRIBER"** means the person whose employment or other status with the Group is the basis for eligibility to receive Covered Services from the Plan.

(s) **"URGENT**" means a situation in which it is determined that no Medical Emergency Condition or Psychiatric Medical Emergency Condition exists, however, the Member is in need of immediate telephone support and/or an appointment with a Plan Provider within 24 to 48 hours to get support for a Serious Personal Problem.

(t) **"VISIT"** means a session between a Plan Provider and Member of approximately 45-50 minutes wherein the Member, individually or with others, discusses problems with a Plan Provider in order to work on resolve the problem. The Member's problems may consist of family conflict, drug or alcohol abuse, stress, marital discord and other personal problems.

(q) **"YOU" or "YOUR"** means the same as Member.

3. CHOICE OF PROVIDER

(a) Choosing a Plan Provider

The Plan maintains a large panel of licensed Plan Providers who have been screened and are monitored by the Plan. You must contact the Plan and the Plan will refer you to the appropriate Plan Provider. You will be referred to a Plan Provider based on where you live or work and the type of problem you wish to address. You may, however, choose from any available Plan Provider. During initial contact with the Plan representative, you must state that you prefer to select your own Plan Provider, in which case the Plan representative will provide a list of all appropriate Plan Providers.

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 or inform the Plan of your intent to select a new Plan Provider from the Plan Provider list. To receive information and assistance, Members should contact the Plan by calling **(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.

(b) Facilities and Availability of Plan Providers

Plan Providers are located close to where you work or live, and are 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 The Plan at **(800) 344-4222**. The Plan does not guarantee the initial or continued availability of any particular Plan Provider.

(c) 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).

(d) 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.

(e) Changing Plan Providers

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

(f) Service Area

If you require Covered Services, 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. The Plan contracts with a large network of Plan Providers. Consequently, the Plan will ensure that you receive in-office Covered Services from a Plan Provider within 30 minutes or 15 miles from your work or home. If you have to travel farther than 15 miles or 30 minutes in order to receive in-office care, immediately inform the Plan and it will direct you to a closer Plan Provider, if available. Alternatively, you may request video counseling from a Plan Provider.

(g) How Are Plan Providers Compensated

The Plan compensates its Plan Providers on what is called a "discounted fee-for-service basis." This means that the Plan pays a Plan Provider for each Visit an amount, which is less than the Plan Provider's usual and customary rate. The Plan's Providers are always required by the Plan to provide services in a quality manner in accordance with detailed regulatory and contractual requirements. These requirements help reduce overall costs by providing quality care, which emphasizes early intervention, and access to effective treatment methods.

4. 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 Members. You 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, 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: 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; (2) within three to five business days of a referral for routine appointments. Plan Providers have agreed to see a Member within 30 minutes of his or her scheduled appointment.

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

5. PREPAYMENT FEES

(a) Members have no obligation to pay for Covered Services provided by the Plan. The full cost of Covered Services, including Prepayment Fees, is paid by the Group. There are no co-payments, co-insurance, or deductible payments applicable to the Plan's Covered Services. All Plan Providers are under contract with the Plan to provide Covered Services.

(b) The Plan may change the Prepayment Fee charged to the Group so long as the Group is provided with a sixty-day prior written notice of the proposed change.

6. OTHER CHARGES

(a) Members are not obligated to pay for Covered Services rendered by the Plan, including the payment of any Prepayment Fees, deductibles, copayments, or coinsurance. By statute, every contract between the Plan and a Plan Provider contains language that states that if the Plan fails to pay a Plan Provider, the Member is not responsible to the Plan Provider for any sums owed by the Plan. In the event that the Plan fails to pay a non-Plan Provider, the Member may be liable to the non-Plan Provider for the costs of services rendered.

(b) If a Member requires non-Covered Services, the Plan Provider or the Plan will refer the Member to other community resources for further care, the cost of which will not be covered by the Plan and will be the responsibility of the Member. If a Member requires non-Covered Services and his or her Plan Provider is able to provide the non-Covered Services, the Member may elect to obtain

care from his or her Plan Provider, the cost of which will not be covered by the Plan and will be solely the financial responsibility of the Member.

7. REIMBURSEMENT PROVISIONS

Covered Services are provided by the Plan at no cost to the Member. In the event that a Plan Provider, or a non-Plan Provider who has been authorized by the Plan to provide the Member with Covered Services, charges a Member for Covered Services and the Member has paid the provider, the Member will be reimbursed by the Plan. For reimbursement, contact the Plan at 1-800-344-4222.

8. DETAILED DESCRIPTION OF COVERED SERVICES

(a) A list of Covered Services is set forth in the Benefit Schedule, which is attached to this document. Descriptions of Covered Services that are not covered are set forth in the Exclusion and Limitations Section. As a Member, you may also contact the Plan at **1-800-344-4222** 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 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. The Plan offers Members the choice of in-office counseling or video counseling.

(c) A Member is entitled to a defined number of Visits with a Plan 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 Members to be assessed and referred to appropriate resources as necessary. When a Member requests a non-Covered Service, the Clinical Manager will assess the need and discuss the scope of Covered Services and non-Covered Services. The Clinical Manager will recommend that the Member 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 Member, Plan Providers, and the public upon request by calling **1-800-344-4222**.

9. LIMITATIONS

(a) General Limitations:

(i) Unless otherwise authorized by the Plan, all Covered Services must be performed by a Plan 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 Member seeking video counseling must receive video counseling from a Plan 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 he or she determines that video counseling is inappropriate for the Member.

10. EXCLUSIONS

The following services are specifically excluded from coverage provided under this EOC. The determination of whether a service is excluded is solely that of the Plan.

(a) Services not listed as a Covered Service.

(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 exclusions 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 (if you have been denied an experimental or investigational treatment, see section 20 regarding the External, Independent Review Process).

(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 preapproved 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 referrals to a community resource 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 impairments is not necessary to determine an appropriate referral to a Plan Provider to receive Covered Services, or alternatively, a 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, referrals to community resource for non-Covered Services.)

(r) Medical treatment for chronic pain.

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

11. 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 Group. Coverage of Covered Dependents begins at the same time.

(b) Identification Card

The Plan does not distribute identification cards to its Members. In order to access care, simply contact the Plan at **1-800-344-4222** and a Plan representative will direct you to an appropriate Plan Provider.

(c) Notifying Members of Changes to the Plan

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

(d) 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.

(e) Confidentiality of Information

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, including your employer, without your prior written consent unless permitted or required by law.

12. TERMINATION OF BENEFITS

(a) A Member's coverage may terminate for any of the following reasons:

(i) The Subscriber is no longer employed by the Group, or no longer meets the eligibility requirements established by the Group. Coverage for the Subscriber and all Covered Dependents will end at 11:59 p.m. on the last day of the month in which the Subscriber's employment or eligibility for coverage ends.

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

(iii) The Member commits fraud or deception in the use of Covered Services, or knowingly permits such fraud or deception of another. Coverage will end thirty (30) days from the date the notice is mailed to the Member.

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

(1) The Group voluntarily terminates the Agreement. Coverage will end as provided for in the Agreement.

(2) 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.

(3) The Group fails to pay Prepayment Fees. The Plan will provide the Group with a thirty (30) day grace period that begins on the first day after the last date of paid coverage to make payment of overdue Prepayment 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 Member's health status or requirements or need for Covered Services.

13. RENEWAL PROVISION

The Agreement for Employee Assistance Services provides for an initial term of one (1) year from the date of its execution, and shall automatically renew for successive one (1) year terms, unless: (1) the Group notifies the Plan in writing ninety (90) days before the end of the contract year of its intent not to renew, or (2) the Group and the Plan, by mutual consent, modify or alter the renewal provision of the Agreement. The Plan shall not increase the amount paid by the Group, nor decrease in any manner the benefits stated in the Agreement, unless written notice of such change has been delivered no less than ninety (90) days 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.

14. CUSTOMER SERVICE INFORMATION

The Customer Service Department is staffed by representatives who are sensitive to your needs, and is available to help you understand this Plan, to help select a Plan Provider, and to assist you with problems you may encounter when using the Plan.

15. GRIEVANCE PROCESS

(a) Members are encouraged to contact the Plan concerning any problems they may have experienced with any aspect of the Plan or its Plan Providers. The Plan has a Member grievance procedure to handle complaints or grievances. For purposes of this section, complaint shall have the same meaning as grievance.

(b) Complaint forms and copies of the grievance procedure are available at the Plan's office, on the Plan's website and from each Plan Provider. Complaint forms will also be sent to Members upon request.

(c) Member complaints or grievances may be submitted to the Plan anytime within 180 calendar days from the time the problem occurred using any of the following methods:

(i) By telephone at **(800) 344-4222**;

(ii) Online at www.concernhealth.com;

(iii) By fax at **(650) 934-2310**;

(iv) In person from 8:30 a.m. to 5:00 p.m. Monday through Friday (holidays excluded) at the Plan address below; or

(v) By mail at the address below.

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

(d) Assistance will be provided by a Plan representative to anyone attempting to file a grievance in person or by telephone, and to those with limited English proficiency or with visual or communicative impairments. Such assistance includes, but is not limited to, translation of grievance procedures, forms, and Plan responses to grievances, as well as access to interpreters, telephone relay systems, and other devices that aid disabled individuals to communicate. These services are made available by the Plan at no charge to the Member.

(e) Members will receive a written response within five (5) calendar days acknowledging receipt of the complaint, except for complaints received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and are resolved by the close of the next business day. Within thirty (30) calendar days, Members will receive a written notice describing the Plan's resolution of the complaint.

(f) For grievances involving the delay, denial or modification of employee assistance services, the Plan response will describe the criteria used and the clinical reasons for its decision, including all criteria and reasons related to the necessity of employee assistance services. In the event that the Plan issues a decision delaying, denying or modifying the employee assistance services based in whole, or in part, on a finding that the proposed services are not a covered benefit under the Agreement for Employee Assistance Services, the Plan will then clearly specify in the decision the provisions in the Agreement that exclude the coverage.

(g) If the Member is not satisfied with the resolution of the complaint he/she may request that the matter be arbitrated. If a request for arbitration is not submitted within 120 days (or such later date if circumstances make it difficult to submit a request within the 120 day time period), the decision of the Plan shall be final and binding. The arbitration will be pursuant to the rules and regulations enforced at the time of occurrence of the American Arbitration Association. The arbitration will take place in the county where the services were provided, or such other mutually

agreeable location. (See Section 16 (Arbitration) below regarding the details of the arbitration process.)

(h) 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.

(i) Non-Discrimination: At no time will the Plan discriminate against a Member on the grounds that the Member 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 **1-800-344-4222** for review.

(j) Review by the Department of Managed Health Care

(i) The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-344-4222** and use your health plan's grievance process before contacting the department. Utilizing the 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 the medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free **telephone number (1-888-466-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's Internet **Web site http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

(ii) If any person believes that a membership has been improperly canceled, rescinded, or not renewed, or a Member has been denied eligibility or services under the Agreement for Employee Assistance Services 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.

(iii) If a Member believes that health care services have been improperly denied, modified, or delayed by the Plan or by a Plan Provider, the Member has the right to request an independent medical review. To initiate a request, the Member must complete an application. The California Department of Managed Health Care will review the application and determine whether the request qualifies for an independent medical review. For more information and application forms, Members may contact the Plan at **1-800-344-4222** or the California Department of Managed Health Care at **1-888-466-2219** (TDD at **1-877-688-9891**) or visit http://www.dmhc.ca.gov.

16. ARBITRATION FOR CALIFORNIA MEMBERS

(a) In addition to the grievance process, a Member may also seek redress by submitting the dispute to binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association. Binding arbitration is the final process for resolution of any dispute described in section (b) below. Under binding arbitration, both parties give up their rights to have the dispute decided by jury in a court of law.

(b) Each and every unresolved disagreement, dispute or controversy arising out of or relating to Covered Services under the Agreement or EOC, or the construction, interpretation, performance or breach of the Agreement or EOC, between a Member or personal representative of such persons, as the case may be, and the Plan shall be submitted to binding arbitration in accordance with this section whether such dispute involves a claim in tort, contract or otherwise, and whether or not other parties (e.g., Plan Providers or their partners, agents, or employees) are involved. **This Arbitration section does not include disputes involving medical malpractice.** If you have a dispute involving medical malpractice, you should consult a lawyer to assist you in determining your legal rights. It does include any act or omission which occurs during the term of this contract but which may give rise to a claim after the termination of this contract.

(c) The Member seeking binding arbitration shall send a written notice to the Plan. 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 to the AAA at 3055 Wilshire Blvd., 7th Floor, Los Angeles, CA 90010-1108, or telephone (213) 383-6515.

(d) 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.

(e) 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.

(f) 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.

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

(h) 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.

(i) The arbitration shall take place in the largest city or town in the county where the 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.

17. SECOND OPINION

(a) Members, or Plan Providers providing Covered Services to Members, may request second opinions from another appropriately qualified Plan Provider by calling the Plan and requesting a second opinion.

(b) The Plan will provide an authorization or denial in an expeditious manner appropriate for the nature of the Member’s condition.

(c) Reasons for a second opinion to be provided or authorized include, but are not limited to, the following:

(i) The reasonableness or necessity of recommendations made is questioned by the Member.

(ii) The indications for treatment are sufficiently complex or confusing that a second opinion may enhance the development of an effective treatment plan.

(iii) The Member has questions about his or her EAP Assessment.

(iv) The Plan Provider is unable to make, or would like additional assistance in making, an EAP Assessment.

(d) Second opinion consultations are provided at no cost to the Member.

18. CONTINUITY OF CARE

(a) Continuity of Care for New Members

(i) New Members who were receiving otherwise Covered Services from a non-Plan Provider at the time his or her employer changed EAP plans may request completion of Covered Services with the non-Plan Provider at the Plan's cost and at no cost to the Member, if the Member notifies the Plan no later than forty-five (45) days after the effective date of coverage.

(ii) The Plan will allow the new Member a reasonable transition period or allot a reasonable number of transitional visits to continue his or her course of treatment with the non-Plan Provider prior to transferring to a Plan Provider. The non-Plan Provider must provide all services on a timely, appropriate, and medically necessary basis.

(iii) In determining the length of the transition period or number of transitional Visits, the Plan will take into account on a case-by-case basis, the severity of the Member's condition, the amount of time reasonably necessary to effect a safe transfer, and the potential clinical effect of a change of provider on the Member's treatment for the condition.

(iv) The Plan may require non-Plan Providers whose services are continued pursuant to this policy to agree in writing to the same contractual terms and conditions that are imposed upon Plan Providers, including reimbursement methodologies and rates of payment. If the non-Plan Provider does not agree to such contractual terms and conditions, the Plan is not required to provide continuation of the non-Plan Provider's services.

(v) If the Plan determines that a Member's treatment should temporarily continue with the Member's existing provider who is a non-Plan Provider, 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 provider.

(vi) The Plan, at its sole discretion, may accept non-Plan Providers onto its panel for the treatment of other Members; however, the Plan is under no obligation to do so.

(vii) All requests for continuity of care and notifications by Members of care being provided by a non-Plan Provider shall be made to the Plan office or by calling 1-800-344-4222. All continuity of care requests are forwarded to one of the Plan's Clinical Managers or Supervisors for action, and reviewed in consultation with the Medical Director, as appropriate. The Clinical Manager or Supervisor shall respond to the Member within an appropriate period of time depending on the assessed severity of the condition involved to ensure safety, and in no event more than five (5) days after submission of the request to the Plan.

(b) Continuity of Care for Current Members

(i) In the event a Plan Provider terminates from the Plan and a Member was receiving Covered Services from such terminated Plan Provider at the time of termination, the Plan will allow the Member to continue to receive such Covered Services from the terminated Plan

Provider at the Plan's cost and at no cost to the Member 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 Member, the Plan will make immediate arrangements to transfer care to a current Plan Provider.

(ii) This provision does not apply to providers who were terminated as a Plan Provider for reasons related to medical disciplinary cause or reason, as defined in Section 805(a)(6) of the California Business and Professions Code, or fraud or other criminal activity.

(c) In either case, the Plan pays the non-Plan Provider up to the maximum number of Visits the Member is entitled to under the Benefits Schedule.

(d) This policy applies to all conditions, including acute, serious, and chronic conditions so long as the service provided is a Covered Service.

(e) Members may request a separate copy of this policy by calling the Plan at 1-800-344-4222.

(f) As used in this section:

(i) "Acute condition" means a mental health condition that involves a sudden onset of symptoms due to an illness, injury, trauma, crisis, or other mental health problem that requires prompt mental health attention and has a limited duration.

(ii) "Serious or chronic condition" means a mental health condition due to a disease, illness, or other mental health problem or disorder that is serious in nature and either:

(1) Persists without full cure or worsens over an extended period of time; or

(2) Requires ongoing treatment to maintain remission or prevent deterioration.

19. INDIVIDUAL CONTINUATION OF BENEFITS

(a) If a Subscriber terminates his or her employment with the Group for any reason (including death), the Subscriber and the Subscriber's spouse or domestic partner and his or her Covered Dependents are able to receive Covered Services from a Plan Provider for whom they are currently receiving care from up to the maximum amount of Visits to which they are entitled, as set forth in the Benefit 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 able to received Covered Services from a Plan Provider for whom he or she is currently receiving care from up to the maximum amount of Visits to which he or she is entitled, as set forth in the Benefit Schedule.

(b) Subscribers and/or their Covered Dependents are entitled to receive Covered Services following the Subscriber's termination of employment if the Member 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 (parenting and childcare resources, adult care resources, financial services, legal consultations); these are not ERISA-regulated benefits and are provided for the Group's convenience for the Plan.

(i) COBRA applies to Non-Government employers with 20 or more employees. To be eligible for COBRA, an employee must be enrolled in an employer's health plan at the time of a "qualifying event". A qualifying event means health care coverage ceases for the Member, and his or her spouse and dependents as a result of: (1) termination from employment or reduction in hours below minimum required for coverage of the covered employee, (2) death of the covered employee, (3) divorce or legal separation from the covered employee, (4) dependent loses dependent eligibility, (5) covered employee is entitled to Medicare benefits, and (6) Member becomes disabled. If a Member, or his or her spouse or dependents loses health care coverage as a result of any of the above events, each are entitled to continue coverage up to at least thirty-six months from the date continuation coverage began. This provision is effective on September 1, 2003, and applies to individuals who begin receiving COBRA coverage on or after January 1, 2003. If a Member, or his or her spouse or dependent, desire continuation coverage under COBRA, the Member, or his or her spouse and dependent, must notify the Group within 60 days of a qualifying event occurring. Failure to do so will disqualify coverage under continuation coverage. Members will receive a notice of eligibility for continuation coverage from the Group. This notice will describe the eligibility requirements and the prepayment fees those selecting continuation coverage must pay. Those selecting coverage must notify the Group, in writing, of his or her desire to elect to continue coverage within 60 days of the latter of: (1) the date coverage ends because of a qualifying event, or (2) the date the Group sent the notice of eligibility for continuation coverage. The premium will be 102% of the regular premium for the 18 month period of coverage, and 150% of the regular premium for months 19-36. The regular premium is the cost to the plan for the same period of coverage for similarly situated non-COBRA beneficiaries. Employees who exhaust federal COBRA may be eligible for additional months of group coverage under Cal-COBRA. This additional coverage must be requested from the Group.

(ii) Cal-COBRA applies to employers with 2-19 eligible employees who lose health care coverage under a group health plan. To be eligible for Cal-COBRA, an employee must be enrolled in an employer's health plan at the time of a "qualifying event". A qualifying event means health care coverage ceases for the Member, and his or her spouse and dependents as a result of: (1) termination from employment or reduction in hours below minimum required for coverage of the covered employee, (2) death of the covered employee, (3) divorce or legal separation from the covered employee, (4) dependent loses dependent eligibility, (5) covered employee is entitled to Medicare benefits, and (6) Member becomes disabled. If a Member, or his or her spouse or dependents loses health care coverage as a result of any of the above events, each are entitled to continue coverage up to at least thirty-six months from the date continuation coverage began. If a Member, or his or her spouse or dependent, desire continuation coverage under Cal-COBRA, the Member, or his or her spouse and dependent, must notify the Group within 60 days of a qualifying event occurring. Failure to do so will disqualify coverage under continuation coverage. Members will receive a notice of

eligibility for continuation coverage from the Group. This notice will describe the eligibility requirements and the prepayment fees those selecting continuation coverage must pay. Those selecting coverage must notify the Group, in writing, of his or her desire to elect to continue coverage within 60 days of the latter of: (1) the date coverage ends because of a qualifying event, or (2) the date the Group sent the notice of eligibility for continuation coverage. A qualified beneficiary electing continuation coverage shall pay to the health care service plan, on or before the due date of each payment but not more frequently than on a monthly basis, not more than 110 percent of the applicable rate charged for a covered employee or, in the case of dependent coverage, not more than 110 percent of the applicable rate charged to a similarly situated individual under the group benefit plan being continued under the group contract. In the case of a qualified beneficiary who is determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, the qualified beneficiary shall be required to pay to the health care service plan an amount no greater than 150 percent of the group rate after the first 18 months of continuation coverage provided pursuant to this section. The first payment of premium must be received within 45 days of the employee's written request for Cal-COBRA coverage. If an employer changes from one health plan to another group plan, it must notify all persons currently receiving Cal-COBRA of their right to continue coverage with the new group plan. The employee would then have to contact the new plan and pay Cal-COBRA premiums to the new health plan.

20. EXTERNAL, INDEPENDENT REVIEW PROCESS

The Plan shall provide an external, independent review to examine the Plan's coverage decisions regarding experimental and investigational therapies for Members who are experiencing a life-threatening condition. The Plan shall notify eligible Members in writing of the opportunity to request the external, independent review within five days of the decision to deny coverage.

21. PUBLIC POLICY PARTICIPATION

(a) 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. This committee consists of: (a) a Board member of the Plan, (b) three (3) Members, and (c) a Plan Provider. Committee members shall each serve a three (3) year term while the Plan's Board member shall be a permanent committee member.

(b) The Public Policy Committee meets quarterly to review 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 members for review and comment. When applicable, recommendations and reports from the Public Policy Committee will be forwarded to the Plan's Board of Directors for review at the next regularly scheduled Board meeting. Receipt of the recommendations and any reports from the Public Policy Committee shall be considered by the Board of Directors and duly noted in the Board's meeting minutes.

(c) Membership in the Public Policy Committee is voluntary, and will be determined by the entire Public Policy Committee with special consideration being made to the ethnicity, geographic location and economic status of a member.

22. MEMBERS' RESPONSIBILITIES

(a) A Member should take responsibility for knowing and understanding the rules and regulations of the Plan and abiding by them in the interest of quality care. All Members should follow prescribed recommendations.

(b) The Member should contact the Plan by telephone at **1-800-344-4222** to make an initial appointment. For in-office Visits, you should arrive at the Plan Provider's office five to ten minutes early on the day of the initial appointment to fill out any necessary paper work. For video counseling Visits, you should fill out the paper work provided to you on the video counseling platform prior to the initial appointment. If you cannot keep an appointment, you are responsible for calling the Plan Provider or the Plan and rescheduling at least 24 hours in advance of the appointment. You may be assessed one Visit against your 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).

23. STATEMENT OF ERISA RIGHTS

As participant in the employee assistance program (the "Plan") provided by the Group through Concern, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to the following.

You can examine, without charge, at the Group's offices and at other specified locations, all documents governing the Plan, including the Agreement for Employee Assistance Services, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You can obtain, upon written request to the Plan Administrator appointed by the Group as shown on page 33, Summary Plan Description, copies of documents governing the operation of the Plan, including the Agreement for Employee Assistance Services, subscriber contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description, referred to as the Combined Evidence of Coverage and Disclosure Form. The Group may make a reasonable charge for the copies.

You can receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continuation of Group Plan Coverage

(a) If a Subscriber terminates his or her employment with the Group for any reason (including death), the Subscriber's spouse or domestic partner and his or her Eligible Dependents are able to receive Covered Services from a Plan Provider for whom they are currently receiving care from up to the maximum amount of Visits to which they are entitled, as set forth in the Benefit 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 able to received Covered Services from

a Plan Provider for whom he or she is currently receiving care from up to the maximum amount of Visits to which he or she is entitled, as set forth in the Benefit Schedule.

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

(i) COBRA applies to Non-Government employers with 20 or more employees. To be eligible for COBRA, an employee must be enrolled in an employer's health plan at the time of a "qualifying event". A qualifying event means health care coverage ceases for the Member, and his or her spouse and dependents as a result of: (1) termination from employment or reduction in hours below minimum required for coverage of the covered employee, (2) death of the covered employee, (3) divorce or legal separation from the covered employee, (4) dependent loses dependent eligibility, (5) covered employee is entitled to Medicare benefits, and (6) Member becomes disabled. If a Member, or his or her spouse or dependents loses health care coverage as a result of any of the above events, each are entitled to continue coverage up to at least thirty-six months from the date continuation coverage began. This provision is effective on September 1, 2003, and applies to individuals who begin receiving COBRA coverage on or after January 1, 2003. If a Member, or his or her spouse or dependent, desire continuation coverage under COBRA, the Member, or his or her spouse and dependent, must notify the Group within 60 days of a qualifying event occurring. Failure to do so will disqualify coverage under continuation coverage. Members will receive a notice of eligibility for continuation coverage from the Group. This notice will describe the eligibility requirements and the prepayment fees those selecting continuation coverage must pay. Those selecting coverage must notify the Group in writing, of his or her desire to elect to continue coverage within 60 days of the latter of: (1) the date coverage ends because of a qualifying event, or (2) the date the Group sent the notice of eligibility for continuation coverage. The premium will be 102% of the regular premium for the 18 month period of coverage, and 150% of the regular premium for months 19-36. The regular premium is the cost to the plan for the same period of coverage for similarly situated non-COBRA beneficiaries.

(ii) You can receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan, when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are

responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Group, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive it within 30 days, you may file a suit in a Federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator at the phone number shown on Exhibit A or contact CONCERN: EAP at **(800) 344-4222**. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security-Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

24. BENEFIT SCHEDULE

The Plan shall provide the following Covered Services:

(a) EAP Assessment, referral to community resources and/or 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 Member shall be limited to a maximum of Six (6) Visits for 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 Member for which the Member 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 a Member is assessed as having a substance abuse problem, the maximum number of Visits shall be ten (10). 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; 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) Members may receive short-term counseling from Plan Providers in-office or through video counseling. The Visit maximum applies regardless of whether counseling is received in-office or through video counseling.

(d) The Plan's EAP services will provide Members with confidential EAP Assessment, Crisis Intervention, short-term counseling, referral to community resources and online tools. The Plan can also refer Members to individuals who provide parenting and childcare resources, legal consultations, financial services, adult care resources.

(e) 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.

(f) 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 that the Member is responsible for payment of costs and fees for services provided.

(g) 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.

CONCERN: Employee Assistance Program

Notice of Privacy Practices
Effective date: July 1, 2017

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.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

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 not 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: Dikshya Adhikari; 2490 Hospital Drive, Suite 310; Mountain View, CA 94040; (800) 344-4222.

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:	LifeLong Medical Care Employee Assistance Program
Name & Address of Employer Sponsoring the Plan:	LifeLong Medical Care 2344 6th Street Berkeley, CA 94710
Employer's I.D. Number:	
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:	LifeLong Medical Care 2344 6th Street Berkeley, CA 94710
Insurance Contracts & Policy Nos.:	Employee Assistance Program Organization No. 824
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 January 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.