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 County of San Mateo and CONCERN and the services offered to its employees. Some of the highlights are:

ELIGIBILITY:

If you are a benefits-eligible employee of the County of San Mateo, you and your benefits-eligible dependents are automatically eligible for Services. No enrollment is necessary.

EMPLOYEE SERVICES:

Short-term counseling, up to Five (5) sessions per problem per year, for problems with:
- Relationships (families, couples, parent/child)
- Emotional issues (stress, depression, anxiety, grief, loss, death)
- Substance abuse issues (alcohol, drugs)

Work/Life Services - Information and Referrals for:
- Parenting & Childcare Resources (daycare, schools, adoption, prenatal)
- Eldercare Resources (housing alternatives, services)
- Legal Consultations (up to 30 minutes with an attorney)
- Financial Services (budgets, credit, home-buying)
- Convenience/Concierge Services (entertainment activities, personal shopping services, household services, vacation planning, reservation requests)

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: EAP o isang tagapayao. Upang humiling ng isang tagasalin ng wika o magtanong tungkol sa nakasulat na impormasyon sa iyong 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员幫助您。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

County of San Mateo

CONCERN: Employee Assistance Program
1503 Grant Road, Suite 120
Mountain View, CA, 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 CONTRACT 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 YOUR EMPLOYER TO OBTAIN A COPY OF YOUR GROUP CONTRACT.

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.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>INTRODUCTION TO THE PLAN</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>DEFINITIONS</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>CHOICE OF PLAN PROVIDER</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>FACILITIES</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>CRISIS INTERVENTION AND URGENT SERVICES</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>PREPAYMENT OF FEES</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>OTHER CHARGES</td>
<td>6</td>
</tr>
<tr>
<td>8</td>
<td>DETAILED DESCRIPTION OF COVERED SERVICES</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>LIMITATIONS</td>
<td>6</td>
</tr>
<tr>
<td>10</td>
<td>EXCLUSIONS</td>
<td>6</td>
</tr>
<tr>
<td>11</td>
<td>GENERAL INFORMATION</td>
<td>8</td>
</tr>
<tr>
<td>12</td>
<td>TERMINATION OF BENEFITS</td>
<td>8</td>
</tr>
<tr>
<td>13</td>
<td>RENEWAL PROVISION</td>
<td>9</td>
</tr>
<tr>
<td>14</td>
<td>CUSTOMER SERVICE INFORMATION</td>
<td>9</td>
</tr>
<tr>
<td>15</td>
<td>GRIEVANCE/APPEAL PROCESS</td>
<td>10</td>
</tr>
<tr>
<td>16</td>
<td>ARBITRATION</td>
<td>11</td>
</tr>
<tr>
<td>17</td>
<td>SECOND OPINION</td>
<td>13</td>
</tr>
<tr>
<td>18</td>
<td>CONTINUITY OF CARE</td>
<td>13</td>
</tr>
<tr>
<td>19</td>
<td>INDIVIDUAL CONTINUATION OF CARE</td>
<td>14</td>
</tr>
<tr>
<td>20</td>
<td>EXTERNAL, INDEPENDENT REVIEW PROCESS</td>
<td>16</td>
</tr>
<tr>
<td>21</td>
<td>PUBLIC POLICY PARTICIPATION</td>
<td>16</td>
</tr>
<tr>
<td>22</td>
<td>MEMBERS’ RESPONSIBILITIES</td>
<td>17</td>
</tr>
<tr>
<td>23</td>
<td>BENEFIT SCHEDULE</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>PRIVACY NOTICE</td>
<td>19</td>
</tr>
</tbody>
</table>
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. In addition, The Plan has made the process of providing assistance to deal with personal problems convenient by eliminating cumbersome claims forms.

2. DEFINITIONS

This document uses the following defined terms:

(a) "COVERED SERVICES" means the services to which you are entitled.

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

(c) "CRISIS INTERVENTION" means the process of responding to a request for immediate services in order to determine whether or not a Medical Emergency Condition or Urgent situation exists and to otherwise assess the needs for short term counseling, referrals to community resources, and/or referrals to Medical Emergency Care.

(d) "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.

(e) "ELIGIBLE DEPENDENT" means the Subscriber's spouse or domestic partner; a domestic partner's or Subscriber's biological child; and a domestic partner's or Subscriber's adopted child. (Coverage for adopted children of a domestic partner or Subscriber begins on the date on which the adoptive child's birth parent or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the Subscriber, or the Subscriber's spouse, the right to control the health care for the adoptive child, or absent a written document, on the date there exists evidence of the Subscriber's or Subscriber's spouse's right to control the health care of the child placed for adoption.) The Plan shall not deny enrollment of a domestic partner's or Subscriber's child on any of the following grounds: (1) the child was born out of wedlock; (2) the child is not claimed as an exemption on the Subscriber's federal income tax return; or (3) the child does not reside with the Subscriber or within The
Plan's service area. Eligible Dependent children must be unmarried and under the age of 19. Dependent unmarried children who are enrolled in an institution of higher education may continue as Eligible Dependents through age 24. Dependent unmarried children who are incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who are dependent upon the Subscriber for support and maintenance, are eligible for continuing membership in this Plan.

(f) "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 Premium due in order for Members to receive Covered Services.

(g) "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.

(h) "MEDICAL EMERGENCY CONDITION" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could usually be expected to result in any of the following:

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

(ii) Serious impairment to bodily functions.

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

(i) "MEMBER" means a person who is enrolled in The Plan and eligible to receive Covered Services and who resides in the United States, Canada or Puerto Rico.

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

(k) "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 California as either a psychologist, clinical social worker, or marriage and family therapist.

(l) "PREMIUMS" or "PREPAYMENT FEES" means the monthly amounts due and payable in advance to The Plan by The Group.

(m) "SERIOUS PERSONAL PROBLEM OR CONDITION" means a circumstance wherein a Member believes he or she requires Covered Services to resolve a Crisis, important, or complex matter.
(n) **SUBSCRIBER** means the person whose employment or other status with The Group is the basis for eligibility to receive Covered Services from The Plan.

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

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

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

3. **CHOICE OF PROVIDER**

(a) Choosing a Plan Provider

Members must contact The Plan and The Plan will direct the Member to the appropriate Plan Provider. The Plan maintains a large panel of licensed Plan Providers who have been screened and are monitored by The Plan. A Plan Provider will be assigned to you based on the city where you prefer to be seen. You may, however, choose from any available Plan Provider in the area you prefer to be seen. 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 the Member’s name and telephone number will be taken and you will be called on the next day with the name of a Plan Provider.

(b) Availability of Plan Providers

(i) The Plan contracts with a comprehensive network of Plan Providers located in your area. The Plan does not guarantee the initial or continued availability of any particular Plan Provider. The availability of a Plan Provider can be obtained by calling The Plan at (800) 344-4222.

(ii) The Member may select any Plan Provider from whom to receive Covered Services. Members can be provided with a list of suitable Plan Providers upon request by calling the Plan at 1-800-344-4222.

(c) Scheduling Appointments

The Plan’s Providers’ offices are open during normal business hours and some offices are open during the evening and weekend. If you cannot keep your scheduled appointment, you are required to notify the Plan Provider’s office at least 24 hours in advance. Members must call The Plan directly to
schedule an initial appointment with a Plan Provider. If a Member requires additional care after the initial appointment, the Member’s Plan Provider will arrange for such care.

(d) Referrals for Non-Covered Services

If the Plan Provider determines that the Member requires non-Covered Services, the Plan Provider will refer the Member to an appropriate health care provider or community resource and the Member will be responsible for the cost of services.

(e) Changing Plan Providers

A Member may transfer to another Plan Provider by contacting The Plan by telephone at (800) 344-4222 and requesting such a transfer

(f) Service Area

The Plan’s service area includes most of California. 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 several hundred Plan Providers within California. Consequently, The Plan will ensure that you receive 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 care, immediately inform The Plan and it will direct you to a closer Plan Provider, if available.

(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. FACILITIES

The Plan’s Provider’s offices are located close to where you work or live. To find out the exact address of a Plan Provider’s office, you may contact The Plan at (800) 344-4222 and you will be asked to provide either the city or zip code where you would like to receive care.

5. CRISIS INTERVENTION AND URGENT SERVICES

(a) 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 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, the Member will be referred to the nearest hospital emergency room (or trauma center), or told to immediately call the 9-1-1- operator for emergency assistance. The Plan does not pay for Medical Emergency Care. **Medical Emergency Care is non-Covered Service.**

(d) 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.

6. **PREPAYMENT OF FEES**

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

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

   (c) 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.

7. **OTHER CHARGES**

Neither The Plan nor a Plan Provider is permitted to charge a Member a copayment, a coinsurance, or a deductible amount for Covered Services. 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.
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.

(c) A Member is entitled to a defined number of Visits with a Plan Provider, as set forth in the Benefit Schedule.

9. **LIMITATIONS**

(a) Unless otherwise authorized by The Plan, all Covered Services must be performed by a Plan Provider.

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.

(i) Services not listed as a Covered Service.

(ii) Medical Emergency Care.

(iii) Acupuncture.

(iv) Aversion therapy.

(v) Biofeedback and hypnotherapy.

(vi) 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.

(vii) 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.

(viii) Medical Treatment or diagnostic testing related to learning disabilities, developmental delays, or educational testing or training.
(ix) Experimental or investigational procedures. (if you have been denied an experimental or investigational treatment, see section 20 regarding the External, Independent Review Process)

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

(xi) Services received from a non-participating provider, unless preapproved by The Plan.

(xii) 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)

(xiii) Sleep therapy.

(xiv) 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.

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

(xvi) 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.)

(xvii) 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.)

(xviii) Medical treatment for chronic pain.

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

11. **GENERAL INFORMATION**

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

You are covered from the first day you become an employee of your Group to the last day you are an employee. Eligible Dependents are covered during the same time you are covered.
(b) 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 required by law.

(c) 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 the Member to an appropriate Plan Provider.

(d) 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 30 days of the effective date of any change.

(e) Family Health Insurance Notification

A non-custodial parent of an Eligible 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 an Eligible 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.

12. TERMINATION OF BENEFITS

(a) Eligibility for covered services for you and your Eligible Dependents will end on the last of the month in which you are an employee of your Group, unless you are currently receiving care. Information regarding the continuation of care is set forth at Section 19 (Individual Continuation of Care). Your coverage will also end for any of the following:

(i) Non-payment of Premiums by The Group.

(ii) Fraud or deception in obtaining Covered Services.

(iii) If you present a threat of danger or harm to any Plan Provider or employee, either through specific verbal threats of intent to do harm or through behavior that may seriously endanger the health or safety of a Plan Provider or employee (e.g., setting fires in a Plan Provider office).

(b) 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.

(i) You and your Eligible Dependent will not be terminated due to you or your Eligible Dependent’s health status or requirements or need for Covered Services.

(ii) If a Member is terminated from his or her employment after receiving the first counseling Visit, but before you have received the full number of Visits in which you are entitled, a Member can still receive at no cost the full number of Visits to which he or she is entitled.

13. RENEWAL PROVISION

The Agreement for Employee Assistance Services provides that the contract shall be for an initial term of 34 months from the date of its execution, with automatic 1-year renewal contract terms unless terminated in writing by either party. If the Agreement is terminated, your Group shall notify you thirty (30) days prior to the termination date. A Member who is receiving Covered Services from a Plan Provider will be entitled to complete his or her care regardless of whether or not The Group renews the contract with The Plan.

14. CUSTOMER SERVICE INFORMATION

The Customer Service Department is staffed by representatives who are sensitive to your needs. This Department 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/APPEAL PROCESS

(a) Any inquiries or complaints about your Plan Provider or any disagreement involving a coverage decision matter shall be made to The Plan by writing or calling The Plan at:

CONCERN: Employee Assistance Program
1503 Grant Road, Suite 120
Mountain View, CA 94040
(800) 344-4222

(b) Members are encouraged to contact The Plan office 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 by Members of The Plan. Members may file grievances anytime with 180 days of the time the problem occurred.

Member complaints or grievances may be made in person at The Plan office from 8:30 a.m. to 5:00 p.m. Monday through Friday (holidays excluded), by telephone at (800) 344-4222, or in writing to the Quality Assurance Clinical Manager at the above address. A grievance form is attached to this Combined Evidence of Coverage and Disclosure Form and is available from The Plan. Staff will be
available at The Plan office to assist Members in completion of this form. Members can also access and complete a grievance form on-line at the CONCERN website at www.concern-eap.com.

(c) Members with limited English proficiency or with visual or communicative impairments will be assisted with the grievance process by the Plan. 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.

(d) Members will receive a written response within three (3) days acknowledging receipt of the complaint, and within thirty (30) days a written notice describing The Plan’s determination of the complaint. If the Member is not satisfied with the resolution, he/she may request the matter be appealed by The Plan’s Quality Improvement Committee for further review.

(e) Appeals from such decisions may be made in writing to the Quality Improvement Committee of the Board of Directors. Members will be informed in writing as to the disposition of the Quality Improvement Committee within thirty (30) days from the receipt of the complaint.

(f) If you are dissatisfied with the resolution of the Quality Improvement Committee, you may submit a complaint to the Board of Directors. The Board of Directors will review the complaint and recommend a resolution within 30 days from the receipt of the complaint.

(g) If the Member is still 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 Board of Directors shall be final and binding. The arbitration will be pursuant to the rules and regulations enforce 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 to understand the arbitration process.)

(h) Expedited Review.

(i) 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, The Plan shall inform you at the time the grievance is lodged that you may immediately contact the Department of Managed Health Care. Additionally, with respect to grievances that may cause an imminent and serious threat to your health, including but not limited to, severe pain, potential loss of life, limb, or major bodily function, The Plan shall 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 days from receipt of the grievance.

(ii) 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.

Page 10
for Employee Assistance Services, The Plan will then clearly specify in the decision the provisions in the contract that exclude the coverage.

(iii) 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-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department’s Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

(h) 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.

(i) Review By the Director: If any person believes that a Member has been canceled or denied eligibility or services under the Agreement for Employee Assistance Services because of a Member’s health status or requirements for health services, 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. The Member may also file a Request for Assistance to the Department of Managed Health Care after participating in The Plan’s grievance procedure for 30 days.

16. ARBITRATION

(a) Arbitration of Disputes: If you are not satisfied with the resolution of your dispute with The Plan, you may contact the Department of Managed Health Care to ask for assistance. After participating in The Plan’s grievance procedure for 30 days, the Department will assist the Members once a Request for Assistance is submitted to the Department of Managed Health Care. If you need assistance in filing the Request for Assistance form, you may either call the Department of Managed Health Care at (800) 400-0815 or The Plan at (800) 344-4222. In addition to the Request for Assistance 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. Under binding arbitration, both parties give up their rights to have the dispute decided by jury in a court of law. Either party may refer the dispute to the American Arbitration Association for resolution.

(b) Binding arbitration is the final process for resolution of any dispute or controversy between a Member or personal representatives of the Member, as the case may be, and The Plan over the services
provided to the Member for any dispute or controversy concerning the construction, interpretation, performance or breach of Covered Services. Member agrees that such disputes shall be submitted to binding arbitration under the appropriate rules of the American Arbitration Association (AAA).

(c) Each and every disagreement, dispute or controversy, which remains unresolved concerning the construction, interpretation, performance or breach relating to the provisions of Covered Services, arising between a Member or Eligible Dependent or personal representative of such persons, as the case may be, and The Plan, its employees or Plan Provider or their partners, agents or employees, shall be submitted to binding arbitration in accordance with this Section whether such dispute involves a claim in tort, contract or otherwise. **This 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.

(d) 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.

(e) 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.

(f) 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.

(g) 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.

(h) 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.

(i) 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.

(j) 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**

Members may request a second opinion for Covered Services by contacting your Plan Provider or The Plan. The Plan provides the Member with an option to obtain a second opinion from another Plan Provider. There is no cost to a Member to obtain a second opinion.

18. **CONTINUITY OF CARE**

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

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

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

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

(d) In cases involving a Member who has an acute condition or a serious chronic condition, a Plan Provider shall furnish the Member with Covered Services for 90 days or a longer period if necessary for a safe transfer to another Plan Provider as determined by The Plan in consultation with the Plan Provider, consistent with good professional practice. For purposes of this section, acute condition means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that of a limited duration. For purposes of this section, serious chronic condition means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that does either of the following: (a) persists without full cure or worsens over an extended period of time, or (b) requires ongoing treatment to maintain remission or prevent deterioration.

19. INDIVIDUAL CONTINUATION OF CARE

(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, eldercare resources, financial services, legal consultations, pet care referrals or concierge services); these are not ERISA-regulated benefits and are provided for The Group's convenience for The Plan.

(i) COBRA applies to Non-Federal 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 County of San Mateo 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 County of San Mateo. This notice will describe the eligibility requirements and the prepayment fees those selecting continuation coverage must pay. Those selecting coverage must notify County of San Mateo, 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 County of San Mateo 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.

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 appointment. On the day of the appointment you should arrive at the office five to ten minutes early to fill out any necessary paper work. If you cannot keep the appointment, you are responsible for calling the Plan Provider or The Plan and rescheduling at least 24 hours in advance of the appointment.

23. **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 and his or her Eligible Dependents shall be limited to a maximum of Five (5) 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. CONCERN provides counseling for the following “problem” issues:

(i) marital and family problems,

(ii) difficulty with relationships,

(iii) emotional distress,

(iv) job stress,

(v) communications or conflict issues,

(vi) substance abuse issues and

(vii) loss and death issues.

(b) The Plan provides a problem-focused form of individual or family outpatient counseling that:

(i) seeks resolution of problems in living rather than basic character changes;

(ii) emphasizes the Member’s skills, strengths and resources;

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

(iv) encourages the Member to practice behavior outside the counseling Visits to promote therapeutic goals.
(c) The Plan's EAP services will provide Members with confidential EAP Assessment, Crisis Intervention, short-term counseling and referral to community resources. The Plan can also provide parenting and childcare resources, legal consultations, financial services, eldercare resources and convenience/concierge services.

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

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

(f) The Plan Provider shall also obtain from a Member a consent form prior to the release of any information concerning said Member, except as required by law. A Plan Provider shall explain such form to each Member.
CONCERN: Employee Assistance Program
1503 Grant Road, Suite 120
Mountain View, CA 94040

NOTICE OF PRIVACY PRACTICES
Effective date: April 14, 2003

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

This Notice tells you about the ways CONCERN: EAP may collect, store, use and disclose your protected health information and your rights concerning your protected health information. “Protected Health Information” is information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

Federal and state laws require us to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

Uses and Disclosures of Your Protected Health Information
We may use and disclose your protected health information for different purposes. The examples below are illustrations of the different types of uses and disclosures that we may make without obtaining your authorization.

- **Payment.** We may use and disclose your protected health information in order to pay for your covered services. For example, we may use your protected health information to process claims or reimburse another party that may be responsible for delivering your service.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers in your diagnosis and treatment.
- **Health Care Operations.** We may use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities, or administrative activities, including data management or customer service. To protect your privacy, we will remove information that identifies you whenever possible.

Other Permitted or Required Disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may release your protected health information to public agencies such as the county coroner.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose your protected health
information to government agencies where there is suspicion of abuse, neglect or domestic violence.

- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g. state insurance departments) for activities authorized by law.

- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.

- **Workers’ Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers’ compensation programs.

**Other Uses or Disclosures With an Authorization**

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

**Your Rights Regarding your Protected Health Information**

You have certain rights regarding protected health information that the Plan maintains about you.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information. We will tell you the cost in advance.

- **Right to Amend Your Protected Health Information.** If you feel that your protected health information maintained by CONCERN: EAP is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request, if for example, you ask us to amend information that was not created by CONCERN: EAP or you ask us to amend a record that is already accurate and complete. If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your
authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (paper or electronically). For additional lists within the same time period, we may charge for providing the accounting. We will tell you the cost in advance.

- **Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

- **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.

**Health Information Security**
CONCERN: EAP requires its employees to follow its security policies and procedures that limit access to health information about members to those employees who need it to perform their job responsibilities. In addition, CONCERN: EAP maintains physical, administrative and technical security measures to safeguard your protected health information.

**Changes to This Notice**
We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any other information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

**Complaints**
If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may file a complaint with us by contacting the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate
against you or penalize you for filing a complaint.

Our Legal Duty
We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

Privacy Officer
CONCERN: EAP
1503 Grant Road, Suite 120
Mountain View, CA 94040
800-344-4222
650-940-7100
650-962-5737 Fax
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).

<table>
<thead>
<tr>
<th>Plan Name:</th>
<th>County of San Mateo Employee Assistance Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name &amp; Address of Employer</td>
<td>County of San Mateo</td>
</tr>
<tr>
<td>Sponsoring the Plan:</td>
<td>455 County Center</td>
</tr>
<tr>
<td></td>
<td>Redwood City, CA 94063-1663</td>
</tr>
<tr>
<td>Employer’s Federal Tax ID Number:</td>
<td>94-6000532</td>
</tr>
<tr>
<td>Type of Plan:</td>
<td>The Plan described in this Summary Plan Description is a “Welfare Benefit Plan” for the purposes of ERISA.</td>
</tr>
<tr>
<td>Plan Administrator &amp; Tel. No.:</td>
<td>CONCERN:EAP</td>
</tr>
<tr>
<td></td>
<td>1-800-344-4222</td>
</tr>
<tr>
<td>Where Legal Process May be Served:</td>
<td>County of San Mateo</td>
</tr>
<tr>
<td></td>
<td>455 County Center</td>
</tr>
<tr>
<td></td>
<td>Redwood City, CA 94063-1663</td>
</tr>
<tr>
<td>Insurance Contracts &amp; Policy Nos.:</td>
<td>Employee Assistance Program</td>
</tr>
<tr>
<td></td>
<td>Organization No. 89</td>
</tr>
<tr>
<td>Sources of Contributions to the Plan:</td>
<td>The Plan is funded by contributions from the employer.</td>
</tr>
<tr>
<td>Plan Year:</td>
<td>The financial records of this Plan are kept on a Plan Year basis. The Plan Year begins March 1, 2010.</td>
</tr>
<tr>
<td>Plan Details:</td>
<td>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.</td>
</tr>
</tbody>
</table>