

CONCERN: Employee Assistance Program

IMPORTANT

This is a summary of highlights of the above-named Benefit Program, a component of the LLNS Health and Welfare Benefit Plan for Employees. Receipt of this document and/or your participation in a Plan and any benefit programs under a Plan do not guarantee your employment or any rights or benefits under a Plan. LLNS reserves the right to amend or terminate each Plan or any benefit program(s) under a Plan at any time. Each Plan and the benefit programs referred to in this summary are governed by a Federal law (known as ERISA), which provides rights and protections to Plan participants and beneficiaries.

For more information on LLNS benefit programs, see the LLNS Health and Welfare Benefit Plan for Employees Summary Plan Description available from the LLNL Benefits Office at 925-422-9955. SPDs are also available electronically at *LLNL Benefits Website for Employees* <https://benefits-int.llnl.gov>

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

The purpose of the EOC is to provide you with a summary of the contract between LLNS and CONCERN: EAP and the services offered to its employees. In addition to the information contained in this Benefit Program Summary, the LLNS Health and Welfare Benefit Plan for Employees Summary Plan Description contains important information about your LLNS health and welfare benefits. The Summary Plan Description (“SPD”) is referred to in this Benefit Program Summary as “your LLNS SPD”.

All benefits and coverages described in this Benefit Program Summary are subject to the terms and conditions under which the benefits are provided. If there is any conflict between the Benefit Program Summary and the insurance contract, the insurance contract will always govern.

For additional information:

LLNL Benefits Office

Mailing address:
P.O. Box 808, L-707
Livermore CA 94551

Street Address:

7000 East Avenue., L-707
Livermore CA 94550

Telephone: (925) 422-9955
Fax: (925) 422-8287
Web Address: <https://benefits-int.llnl.gov/>

Some of the highlights are:

ELIGIBILITY:

If you are a benefits-eligible employee of LLNS, 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)
- Older Adult Resources (housing alternatives, services)
- Legal Consultations (up to 30 minutes with an attorney)
- Financial Services (budgets, credit, home-buying)
- Career Management (promotional interviews, performance reviews, career pathing, continuing education)

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

LLNS

**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 AND THE LLNS HEALTH AND WELFARE BENEFIT PLAN FOR EMPLOYEES (PLAN) 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 AND PLAN DOCUMENT.

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 BENEFIT PROGRAM

CONCERN: Employee Assistance Program (“The Benefit Program”) is a prepaid employee assistance plan. The Benefit Program 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 Benefit Program has a panel of Benefit Program Providers from whom to select. All of the services performed by Benefit Program Providers are covered at no cost to you as a Member. In addition, the Benefit Program 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) "**BENEFIT PROGRAM**" means CONCERN: Employee Assistance Program.

(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 Benefit Program 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 definition as provided in your LLNS SPD.

(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) **“LLNL”** means Lawrence Livermore National Laboratory.

(j) **“LLNS”** means Lawrence Livermore National Security, LLC.

(k) **“LLNS SPD”** means the LLNS Health and Welfare Benefit Plan for Employees Summary Plan Description.

(l) **“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.

(m) **“PLAN” or “THE PLAN”** means the LLNS Health and Welfare Benefit Plan for Employees.

(i) **“BENEFIT PROGRAM PROVIDER”** means a person who has entered into a Benefit Program Provider contract with the Benefit Program to provide Covered Services to Members, and who is licensed in California as a psychologist, clinical social worker, or marriage and family therapist.

(j) **“PREMIUMS” or “PREPAYMENT FEES”** means the monthly amounts due and payable in advance to the Benefit Program by The Group.

(k) **“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.

(l) **“SUBSCRIBER”** means the person whose employment or other status with The Group is the basis for eligibility to receive Covered Services from the Benefit Program.

(m) **“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 Benefit Program Provider within 24 to 48 hours to resolve a Serious Personal Problem or Condition.

(n) **“VISIT”** means a session between a Benefit Program Provider and Member of approximately one hour in length wherein the Member, individually or with others, discuss problems with a Benefit Program 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 Benefit Program Provider

Members must contact the Benefit Program and the Benefit Program will direct the Member to the appropriate Benefit Program Provider. The Benefit Program maintains a large panel of licensed Benefit Program Providers who have been screened and are monitored by the Benefit Program. A Benefit Program Provider will be assigned to you based on the city where you prefer to be seen. You may, however, choose from any available Benefit Program Provider in the area you prefer to be seen. To receive information and assistance, Members should contact the Benefit Program by calling **(800) 344-4222**. This phone number is available 24 hours a day, 7 days a week. You may call and request a Benefit Program 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 Benefit Program Provider.

(b) Availability of Benefit Program Providers

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

(ii) The Member may select any Benefit Program Provider from whom to receive Covered Services.

(c) Scheduling Appointments

The Benefit Program’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 Benefit Program Provider’s office at least 24 hours in advance. Members must call the Benefit Program directly to schedule an initial appointment with

a Benefit Program Provider. If a Member requires additional care after the initial appointment, the Member's Benefit Program Provider will arrange for such care.

(d) Referrals for Non-Covered Services

If the Benefit Program Provider determines that the Member requires non-Covered Services, the Benefit Program 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 Benefit Program Providers

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

(f) Service Area

The Benefit Program's service area includes most of California. If you require Covered Services, please contact Benefit Program and you will be advised of the closest Benefit Program Provider from your work or home who will provide the care you require. The Benefit Program contracts with several hundred Benefit Program Providers within California. Consequently, The Benefit Program will ensure that you receive Covered Services from a Benefit Program 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 Benefit Program and it will direct you to a closer Benefit Program Provider, if available.

(g) How Are Benefit Program Providers Compensated

The Benefit Program compensates its Benefit Program Providers on what is called a "discounted fee-for-service basis." This means that the Benefit Program pays a Benefit Program Provider for each Visit an amount, which is less than the Benefit Program Provider's usual and customary rate. The Benefit Program's Providers are always required by the Benefit Program 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 Benefit Program Provider's offices are located close to where you work or live. To find out the exact address of a Benefit Program Provider's office, you may contact the Benefit Program 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 Benefit Program arranges for the provision of Crisis Intervention 24 hours a day, seven days a week, to all Members. You must contact the Benefit Program 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 Benefit Program Provider may contact the Benefit Program at any time (24 hours a day) to obtain an EAP Assessment or referrals for care. A Member will be referred to a Benefit Program Provider so that care is provided (1) within 24 to 48 hours in Urgent cases; (2) within three to five days of a referral for routine appointments. Benefit Program Providers have agreed to see a patient within 30 minutes of his or her scheduled appointment.

(c) Medical Emergency Care: If it is determined by a Benefit Program 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 Benefit Program does not pay for Medical Emergency Care. **Medical Emergency Care is non-Covered Service.**

(d) The processes, criteria and procedures that the Benefit Program uses to authorize, modify, or deny employee assistance services under the benefits provided by the Benefit Program are available to the Member, Benefit Program 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 Benefit Program. The full cost of Covered Services is paid by your Group. There are no co-payments, co-insurance, or deductible payments applicable to the Benefit Program's services. All Benefit Program Providers are under contract with the Benefit Program to provide Covered Services.

(b) The Benefit Program 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 Benefit Program and a Benefit Program Provider contains language that states that if the Benefit Program fails to pay a Benefit Program Provider, the Member is not responsible to the Benefit Program Provider for any sums owed by the Benefit Program. In the event that the Benefit Program fails to pay a non-Benefit Program Provider, the Member may be liable to the non-Benefit Program Provider for the costs of services rendered.

7. OTHER CHARGES

Neither the Benefit Program nor a Benefit Program 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 Benefit Program Provider or the Benefit Program will refer the Member to other community resources for further care, the cost of which will not be covered by the Benefit Program and will be the responsibility of the Member. If a Member requires non-Covered Services and his or her Benefit Program Provider is able to provide the non-Covered Services, the Member may elect to obtain care from his or her Benefit Program Provider, the cost of which will not be covered by the Benefit Program 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. A description of Covered Services that are not covered are set forth in the Exclusion and Limitations Section. As a Member you may also contact the Benefit Program at **1-800-344-4222** to find out if a particular service is or is not covered.

(b) The Benefit Program provides an EAP Assessment, short-term counseling and referrals to community resources. The Benefit Program 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 Benefit Program Provider, as set forth in the Benefit Schedule.

9. LIMITATIONS

(a) Unless otherwise authorized by the Benefit Program, all Covered Services must be performed by a Benefit Program 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 Benefit Program.

- (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 Benefit Program.
- (xii) Psychological testing. (psychological testing is not necessary to determine an appropriate referral to a Benefit Program 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 Benefit Program 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 Benefit Program 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 Benefit Program 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 Benefit Program does not distribute identification cards to its Members. In order to access care, simply contact the Benefit Program at **1-800-344-4222** and a Benefit Program representative will direct the Member to an appropriate Benefit Program Provider.

(d) Notifying Members of Changes to the Benefit Program

If your Covered Services change during the time you are covered, the Benefit Program, 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 Benefit Program Membership, Combined Evidence of Coverage and Disclosure Form, and all other information provided to the covered parent about the child's coverage. The Benefit Program 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 Benefit Program with a medical child support order. Lastly, the Benefit Program 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 Benefit Program 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 Benefit Program Provider or employee (e.g., setting fires in a Benefit Program Provider office).

(b) All requests for Covered Services that involve an EAP Assessment and referral are approved. The Benefit Program 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 twelve 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 Benefit Program Provider will be entitled to complete his or her care regardless of whether or not The Group renews the contract with the Benefit Program.

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 Benefit Program, to help select a Benefit Program Provider, and to assist you with problems you may encounter when using the Benefit Program.

ERISA CLAIMS AND APPEALS PROCESS

This Benefit Program is subject to ERISA Claims and Appeals Procedures. See your LLNS SPD for more information.

15. GRIEVANCE/APPEAL PROCESS

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

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

(b) Members are encouraged to contact the Benefit Program office concerning any problems they may have experienced with any aspect of the Benefit Program or its Benefit Program Providers. The Benefit Program has a Member grievance procedure to handle complaints or grievances by Members of the Benefit Program. Member complaints or grievances may be made in person at the Benefit Program 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 Customer Services Department at the above address.** A grievance form is attached to this Combined Evidence of Coverage and Disclosure Form and is available from the Benefit Program. Staff will be available at the Benefit Program office to assist Members in completion of this form.

(c) 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 Benefit Program's determination of the complaint. If the Member is not satisfied with the resolution, he/she may request the matter be appealed by the Benefit Program's Quality Improvement Committee for further review.

(d) 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.

(e) 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.

(f) 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.)

(g) 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 Benefit Program 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 Benefit Program 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 Benefit Program 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 Benefit Program 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 Benefit Program 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 Benefit Program discriminate against a Member on the grounds that the Member filed a grievance against the Benefit Program or Benefit Program 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 Benefit Program'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 Benefit Program, you may contact the Department of Managed Health Care to ask for assistance. After participating in the Benefit Program'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 Benefit Program 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 Benefit Program, its employees or Benefit Program 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 Benefit Program. 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 Benefit Program. 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 Benefit Program 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 Benefit Program 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 Benefit Program Provider or the Benefit Program. The Benefit Program provides the Member with an option to obtain a second opinion from another Benefit Program 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-Benefit Program Provider for an otherwise Covered Benefit, if the Member notifies the Benefit Program 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 Benefit Program shall either:

(i) Make immediate arrangements to provide care to the Member for the condition through a Benefit Program 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-Benefit Program Provider at the Benefit Program's cost for the condition until the Benefit Program can arrange to transfer the Member's care for that condition to a Benefit Program Provider. The Benefit Program 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 Benefit Program Provider terminates from the Benefit Program and a Member is currently receiving care from such terminated Benefit Program Provider, the Benefit Program requires that the Benefit Program Provider continue to provide care at the Benefit Program's cost, up to the number of Visits the Member is entitled to under the Benefit Schedule. If for any reason the Benefit Program Provider is not available to complete the care provided, the Benefit Program will make immediate arrangements to provide care to the Member through a transfer to another Benefit Program Provider.

(c) All such notifications by a Member may be made to any Benefit Program office. All such notifications shall be forwarded to the Benefit Program'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 Benefit Program.

(d) In cases involving a Member who has an acute condition or a serious chronic condition, a Benefit Program Provider shall furnish the Member with Covered Services for 90 days or a longer period if necessary for a safe transfer to another Benefit Program Provider as determined by the Benefit Program in consultation with the Benefit Program 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

(See your LLNS SPD for COBRA and other continuation of coverage information.)

(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 Benefit Program 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 Benefit Program 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) or California COBRA (Cal-COBRA), as appropriate. Covered Services under COBRA or Cal-COBRA do not include Work/Life services (parenting and childcare resources, older adult resources, financial services, legal consultations, or career management); these are not ERISA-regulated benefits and are provided for The Group's convenience for the Benefit Program.

(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 LLNS 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 LLNS. This notice will describe the eligibility requirements and the prepayment fees those selecting continuation coverage must pay. Those selecting coverage must notify LLNS, 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 LLNS 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 LLNS.

(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 LLNS 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 LLNS. This notice will describe the eligibility requirements and the prepayment fees those selecting continuation coverage must pay. Those selecting coverage must notify LLNS, 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 LLNS 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 Benefit Program shall provide an external, independent review to examine the Benefit Program's coverage decisions regarding experimental and investigational therapies for Members who are experiencing a life-threatening condition. The Benefit Program 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 Benefit Program seeks applicants who would be interested in participating in the Public Policy Committee for the purposes of establishing the public policy of the Benefit Program. This committee consists of: (a) a Board member of the Benefit Program, (b) three (3) Members, and (c) a Benefit Program Provider. Committee members shall each serve a one (1) year term while the Benefit Program's Board member shall be a permanent committee member. The Benefit Program will reimburse Providers \$150.00 per meeting for their participation.

(b) The Public Policy Committee meets quarterly to review the Benefit Program's performance and future direction of the Benefit Program operations. Information regarding the Benefit Program operations, grievance log reports, financial operations and the like will be made available to members for review and comment. Recommendations and reports from the Public Policy Committee will be made to the Benefit Program's Board of Directors 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 Benefit Program and abiding by them in the interest of quality care. All Members should follow prescribed recommendations.

(b) The Member should contact the Benefit Program 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 Benefit Program Provider or the Benefit Program and rescheduling at least 24 hours in advance of the appointment.

23. BENEFIT SCHEDULE

The Benefit Program shall provide the following Covered Services:

(a) EAP Assessment, referral to community resources, and/or Medical Emergency Care, and short-term counseling. The Benefit Program 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 Benefit Program 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 Benefit Program's EAP services will provide Members with confidential EAP Assessment, Crisis Intervention, short-term counseling and referral to community resources. The Benefit Program can also provide childcare assistance, legal consultations, financial counseling, older adult resource referrals, and help with career management.

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

(e) A Benefit Program 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 Benefit Program 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 Benefit Program 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 Benefit Program 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