CONCERN: EMPLOYEE ASSISTANCE PROGRAM
Amendment #1 to Agreement for Employee Assistance Services
by and between
CONCERN: EAP and Monterey Bay Area Self-Insurance Authority

This Amendment #1 to Agreement for Employee Assistance Services (the "Amendment #1") is made by and between CONCERN: Employee Assistance Program (the "Plan") and Monterey Bay Area Self-Insurance Authority (the "Group") as of August 1, 2025 ("Amendment Effective Date").

WHEREAS, the Plan and the Group entered into and executed that certain Agreement for Employee Assistance Services dated August 1, 2023 (the "Agreement").

WHEREAS, the Plan and the Group now desire to amend the Agreement as set forth below.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, the parties agree to amend the Agreement as follows:

1. **Term.** This amendment #1 is in effect for the term of August 1, 2025, to July 1, 2026. This term may be extended or modified by a written amendment, which must be executed by the Plan and the Group.

2. **Attachment A**. Section N is added to the Agreement as follows:

   N. Effective January 1, 2025, the Plan offers Personal Coaching services for a wide range of personal and professional goals at no additional cost for each Member and their Covered Dependents. This benefit includes four 30-minute phone sessions with a certified coach, per twelve-month period, beginning with the date of the case opening. Topics include, but are not limited to; stress management, life balance, setting priorities, personal growth, and work effectiveness.

3. **Fees.** No changes in fees will occur for the duration of the entire term indicated above. The rate remains $9.50 per employee per month for First Responder and $4.30 per employee per month for Non-First Responder.

4. **Effect of Amendment.** Except as set forth in this Amendment #1, the Agreement remains in full force and effect, according to its terms.

IN WITNESS WHEREOF, the Plan and Group have executed this Amendment #1 on the dates set forth below, to be effective as of the date set forth above.

CONCERN: Employee Assistance Program		Monterey Bay Area Self-Insurance Authority	
Name Sign:	DocuSigned by: Cecile Currier DFC544DF1FBA4FD...	Name Sign:	
Name Print:	Cecile Currier	Name Print:	Conor Boughey
Title:	CEO	Title:	MBASIA Program Administrator
Date:	1/31/2025	Date:	1/27/2025
	2490 Hospital Drive, Suite 310 Mountain View, CA 94040		560 Mission Street, 6th Floor San Francisco, CA 94105

CONCERN: EMPLOYEE ASSISTANCE PROGRAM

AGREEMENT FOR EMPLOYEE ASSISTANCE SERVICES

FOR

MONTEREY BAY AREA SELF-INSURANCE AUTHORITY

August 1, 2023 – July 31, 2025

TABLE OF CONTENTS

AGREEMENT FOR EMPLOYEE ASSISTANCE SERVICES
PREPAID CONTRACT

This Agreement for Employee Assistance Services ("Prepaid Contract)" including the Attachments thereto by and between **CONCERN: EAP**, a California corporation (hereinafter designated "Plan" or "The Plan"), and **Monterey Bay Area Self-Insurance Authority** (hereinafter designated as "Group" or "The Group") is effective on August 1, 2023 (the "Effective Date").

RECITALS

WHEREAS, The Group wishes to establish an Employee Assistance Program as defined herein, for the benefit of its employees and their Covered Dependents.

WHEREAS, The Plan is licensed as a specialized health care service plan under the Knox-Keene Health Care Service Plan Act of 1975, as amended.

WHEREAS, The Plan has experience in providing Employee Assistance Program services and has established a network of professional providers to render required Employee Assistance Program services.

WHEREAS, The Group wishes to engage The Plan to provide such services and The Plan wishes to provide the same on the terms and conditions set forth herein;

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, the parties agree as follows:

1. Definitions

1.1 **"Agreement"** means the Agreement for Employee Assistance Services between The Plan and The Group, including Attachments A, B, C and D. Attachments A, B, C and D are incorporated herein by this reference.

1.2 **"Covered Dependent"** means the Subscriber's spouse or domestic partner, Subscriber's biological child, Subscriber's adopted child or step-child, or domestic partner's biological or adopted child. (Coverage for adopted children of a Subscriber or domestic partner begins on the date on which the adoptive child's birth parent or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the Subscriber, or the Subscriber's spouse or domestic partner the right to control health care for the adoptive child, or absent a written document, on the date there exists evidence of the Subscriber's or Subscriber's spouse's or domestic partner's right to control the health care of the child placed for adoption.) The Plan shall not deny enrollment of a Subscriber's child or a subscriber's domestic partner children on any of the following grounds: (1) the child was born out of wedlock; (2) the child is not claimed as an exemption on the Subscriber's federal income tax return; or (3) the child does not reside with the Subscriber or within The Plan's service area. Dependent children are covered under the age of twenty-six (26). Dependent children who are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and who are chiefly dependent upon the Subscriber for support and maintenance, are eligible for continuing membership in The Plan.

1.3 **"Covered Services"** means those services, which are provided by The Plan to Members and set forth in Attachment A to this Agreement.

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

1.5 **"Crisis Intervention"** means the process of responding to a request for immediate services to determine whether or not a Medical Emergency Condition, Psychiatric Medical Emergency Condition, or Urgent situation exists, and to otherwise assess the need for short-term counseling, referrals to community resources, and/or referrals to Medical Emergency Care.

1.6 **"Employee"** means a full-time or regular part-time employee or other eligible employee as defined by The Group.

1.7 **"Employee Assistance Program (EAP) Assessment"** means the process of determining, based upon information provided by a Member, the need for either:

a. Short-term counseling;

b. Referral(s) to community resources; or

c. Referral(s) to Medical Emergency Care services or treatment.

1.8 **"Employee Assistance Program (EAP) Benefits"** means a systematic program to help employees resolve personal problems, such as family conflict, drug or alcohol abuse, stress, marital discord, and other personal problems, and to provide training, consultation, and other management services relating to the effective utilization of this benefit by employers and their employees.

1.9 **"Grievance"** means a written or oral expression of dissatisfaction regarding the Plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. Grievances may be communicated to The Plan via telephone, FAX, e-mail, on-line through the Plan website, or submission of a written grievance form.

1.10 **"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.

1.11 **"Medical Emergency Condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

a. Placing the patient's health in serious jeopardy.

b. Serious impairment to bodily functions.

c. Serious dysfunction of any bodily organ or part.

1.12 **"Member"** means a person who is enrolled in The Plan and eligible to receive Covered Services. Member includes the Subscriber and any Covered Dependents.

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

1.14 **"Prepayment Fees"** means the periodic Prepayment Fees set forth in Attachment B, which The Group agrees to pay The Plan for Covered Services.

1.15 **"Psychiatric Medical Emergency Condition"** means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

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

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

1.16 **"Subscriber"** means an Employee of The Group who: (a) meets all applicable eligibility requirements as established by The Group; and (b) on whose behalf The Group has paid, and The Plan has received, any applicable Prepayment Fees in accordance with section 3.3 of the Agreement.

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

1.18 **"Visit"** means a session between a Plan Provider and Member of approximately 45-50 minutes wherein the Member, individually or with others, discusses problems with a Plan Provider in order to work on or resolve the problem.

2. Responsibilities of the Plan

2.1 **Covered Services:** The Plan shall provide to The Group those benefits set forth in Attachment A, which is appended hereto. Said benefits shall be provided through Plan

Providers who have agreed to enter into a written contract with The Plan.

a. All Plan Providers shall be appropriately licensed and shall comply with professionally recognized standards of practice and all applicable state and federal laws.

b. The Plan shall not decrease in any manner the Covered Services set forth in the Attachment(s) except after notifying The Group at least sixty (60) days in advance by means of a postage paid mailing, or by any electronic means, which will be deemed to have the same effect as physical delivery of the paper document. Compensation to The Plan shall be reduced commensurate to any reduction in services.

2.2 Quality Assurance: The Plan shall establish and maintain a quality assurance review program throughout the term of this Agreement. A standing Quality Improvement Committee meets on a quarterly basis, and is chaired by the Plan Medical Director. The Committee consists of two providers for the Plan and two staff positions. The Committee reports directly to the Board of Directors. The Quality Improvement Committee serves as an oversight of the Quality Management Committee, and as such, regularly reviews the reports compiled by the Quality Management Committee, as well as provides feedback and recommendations regarding potential performance improvement projects.

2.3 Confidentiality of Records: The Plan shall comply at all times with the California Confidentiality of Medical Information Act (California Civil Code section 56 et seq.) and any other state or federal law applicable to the services provided under this Agreement. Compliance to Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines will be maintained in regard to confidentiality of all records. Information related to the identity, medical diagnosis, or treatment provided to any Member shall be kept confidential and shall not be disclosed by The Plan or any Plan Provider to The Group without the prior written consent of the person who is receiving care (or the legal representative of such person). Prior to the release of any confidential information, record, documentation or the like, the Member shall provide to The Plan a signed Release of Information form. The Release of Information form describes in full the extent and scope of information to be released. If a Member has any questions regarding the Release of Information form, he or she should contact The Plan. All records, files or other materials obtained in connection with this Agreement (including those related to individual employees of The Group or their families) shall be the property of The Plan.

2.4 Medical Emergency Care: If a Member feels the situation constitutes a Medical Emergency Condition or Psychiatric Medical Emergency Condition, the Member should seek care at the nearest hospital emergency room (or trauma center), or immediately call the 911 operator for emergency assistance. The Plan does not pay for Medical Emergency Care. **Medical Emergency Care treatment is a non-Covered Service**. A Plan Provider can assist the Member in accessing Medical Emergency Care services.

2.5 Crisis Intervention, Urgent and Routine Appointments

a. The Plan arranges for the provision of Crisis Intervention 24 hours a day, seven days a week, to all Members. Members must contact The Plan at **1-800-344-4222** for Crisis Intervention services. Crisis Intervention is the process of responding to a request for immediate services in order to determine whether or not a Medical Emergency Condition, Psychiatric Medical Emergency Condition, or Urgent situation exists and to otherwise assess the needs for short term counseling, referrals to community resources, and/or referrals to Medical Emergency Care or treatment.

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 within 24 to 48 hours in urgent cases.

c. Routine appointment: Offered within 3-5 days.

2.6 Access to Plan's Processes, Criteria and Procedures for Claim Review: 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. Members, Plan Providers and the public may contact The Plan at **1-800- 344-4222** to obtain a copy of the processes, criteria and procedures that The Plan uses to authorize, modify, or deny employee assistance services under the benefits provided by The Plan.

2.7 Family Health Insurance Notification: A non-custodial parent of a Covered Dependent child is entitled to inspect the child's Plan Membership, Combined Evidence of Coverage and Disclosure Form, and all other information provided to the covered parent about the child's coverage. The Plan will also notify both parents (including the non-covered custodial parent) if a Covered Dependent child's coverage is terminated, provided that the parent has provided The Plan with a medical child support order. Lastly, The Plan will respond to telephone or written inquiries from a non-covered custodial parent concerning a child's health coverage.

3. Responsibilities of The Group

3.1 Information to Members: The Group shall provide Members with information concerning this Agreement, including making copies available of the combined evidence of coverage and disclosure form, which shall be furnished to The Group by The Plan.

3.2 Provide Headcounts: The Group will provide an accurate headcount of all employees covered by The Plan at the beginning of each month.

3.3 Prepayment Fees: The Group shall pay The Plan the Prepayment Fees set forth in Attachment B, which is appended hereto and incorporated by this reference. The Plan shall not increase the amount set forth in Attachment B, except after notifying the Group at least sixty (60) days in advance of the rate change by means of a postage

paid mailing or by any electronic means, which will be deemed to have the same effect as physical delivery of the paper document.

4. Relationship Between the Parties

4.1 **Independent Contractor:** The Plan shall perform its duties under this Agreement as an independent contractor. Nothing contained in this Agreement shall be construed to create the relationship of principal and agent, employer and employee, partners or joint venture between the parties.

4.2 **Each Party Responsible for its Own Acts:** The Plan and The Group are each responsible for their own acts and/or omissions and are not responsible for the acts and/or omissions of the other party, its employees, independent contractors, directors, officers, agents or representatives.

4.3 **Insurance:** The Plan is covered by professional liability insurance. The coverage is $10,000,000 per claim or $20,000,000 aggregate. A copy of the Certificate of Insurance is attached (Attachment C). The Plan will notify The Group if there is any change in coverage. The Plan also has a Workers' Compensation Certificate of Consent to Self-Insure.

5. Coverage, Obtaining Covered Services, Limitations, and Exclusions

5.1 **Eligibility**: An individual is eligible to receive Covered Services under this Agreement if he or she is an Employee who works or resides in the Plan's service area and meets any additional eligibility requirements as established by The Group, or a Covered Dependent of the Employee.

5.2 **Coverage**: The Plan covers assessments, referrals, crisis intervention and short-term counseling. A Member is entitled to a defined number of visits with a counselor, as set forth in the Covered Services, Attachment A. The Plan can assist with most personal problems including marital and family problems, difficulty with relationships, emotional distress, job stress, communications or conflict issues, substance abuse issues and loss and death.

5.3 **Obtaining Covered Services:** The Plan does not distribute identification cards to its Members. In order to access care, Members should contact The Plan at **1-800-344-4222** and a Plan representative will direct the Member to an appropriate Plan Provider.

5.4 **Limitations:** Unless otherwise authorized by The Plan, all Covered Services must be performed by a Plan Provider. The number of visits to a member is limited, specified in Attachment A.

5.5 **Exclusions:** The following services are specifically excluded from Covered Services provided under this Agreement. All denials, modifications, and delays of requested services are subject to The Plan's grievance review process. (See Section 17 for the Grievance Procedure.)

a. Services not listed as Covered Services.

b. Medical Emergency Care.

c. Acupuncture.

d. Aversion therapy.

e. Biofeedback and hypnotherapy.

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

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

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

i. Experimental or investigational procedures.

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

k. Services received from a non-Plan Provider, unless pre-approved by The Plan.

l. Psychological testing. (psychological testing is not necessary to determine an appropriate referral to a Plan Provider to receive Covered Services, or alternatively, to determine appropriate referrals to community resources for non-covered services)

m. Sleep therapy.

n. Examinations and diagnostic services in connection with the following: obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; securing insurance coverage; foreign travel or school admissions.

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

p. Medical treatment for speech and hearing impairments. (A speech or hearing impaired Member is entitled to Covered Services. Treatment for speech and hearing impairment is not necessary to determine an appropriate referral to a Plan Provider to receive Covered Services, or

alternatively, to determine appropriate referral to community resources for non-covered services.)

q. IQ testing. (IQ testing is not necessary to determine an appropriate referral to a Plan Provider to receive Covered Services, or alternatively, to determine appropriate referral to community resources for non-covered services.)

r. Medical treatment for chronic pain.

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

6. Choice of Plan Providers

The Plan will assign a Plan Provider who will deliver services to a Member. In assigning a Plan Provider to a Member, The Plan will consider where the Member lives and works in relationship to a Plan Provider's office. Naturally, Plan Providers will be matched with a Member who lives or works in close proximity to a Plan Provider's office. If the Member prefers to select his or her own Plan Provider, the Member may choose from any available Plan Provider. The Member must state during the initial contact to The Plan representative that he or she prefers to select his or her own Plan Provider, in which case The Plan representative shall provide a list of all Plan Providers that have offices in the geographic area where the Member desires to be seen. If the Member is assigned a Plan Provider or selects one he or she is dissatisfied with, the Member may contact The Plan and request to be reassigned a new Plan Provider or inform the Plan of his or her intent to select a new Plan Provider from the Plan Provider list.

7. Other Charges

No Member shall be obligated in any way to pay for services rendered by The Plan in accordance with the terms of this Agreement, including the payment of any Prepayment Fees, deductibles, copayments, or co-insurance.

8. Member Liability for Services Rendered

By statute, every contract between The Plan and its Plan Providers provides that in the event that The Plan fails to pay the Plan Provider, the Member shall not be liable to that Plan Provider for any sums owed by The Plan. If The Plan fails to pay a non-Plan Provider, the Member could be liable to the non-Plan Provider for the cost of services.

9. Reimbursement Provisions

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

10. Term and Termination

10.1 Term: This Agreement shall become effective at 12:01 a.m. on the Effective Date. This Agreement shall continue to remain in full force and effect for a period of two (2) years from the Effective Date unless renewed pursuant to section 10.7 of this Agreement (the "Term").

10.2 Group Termination: The Group shall have the right to terminate this Agreement immediately upon notice to The Plan in the following circumstances:

a. Application for or appointment of a receiver, trustee in bankruptcy or liquidator of The Plan;

b. The Plan's loss of licensure as a specialized health care service plan pursuant to the provisions of the Knox-Keene Act; or

c. Upon 30 days prior written notice in the case The Plan breaches this Agreement and fails to cure within the 30 days written notice period.

The Group shall have the right to terminate this Agreement for any other reason by sending written notice of such termination to the Plan. Such termination shall be effective 120 days after the date on which The Group has sent the notice or the date specified in such notice, whichever is later.

10.3 Plan Termination: The Plan shall have the right to terminate this Agreement in the following circumstances:

a. Failure to Pay the Prepayment Fees: The Plan shall send a Notice of Consequences for Nonpayment of Prepayment Fees with the billing invoice, which shall include the Prepayment Fee due date, a description of the consequences for failure to pay Prepayment Fees by the due date, and a statement that The Plan will continue to provide coverage during a 30-day grace period that begins on the first day after the last day of paid coverage. If Prepayment Fees are not received by The Plan by the due date stated in the billing invoice, The Plan shall send The Group a Notice of Termination for Nonpayment of Prepayment Fees and Grace Period no later than five (5) business days after the last day of paid coverage. The Notice of Termination for Nonpayment of Prepayment Fees and Grace Period will include the reason for termination, the date of the last day of paid coverage, the effective date of termination, the dollar amount due to The Plan, a description of the duration and effect of the grace period, the date the grace period begins and ends, any obligations of The Group, and an explanation of the right to request a review from the Director of the Department of Managed Health Care. Within five (5) business days of the effective date of termination, The Plan will send The Group a Confirmation Notice confirming such termination. The Plan shall reinstate coverage after termination of this Agreement if payment of the required Prepayment Fees is received within 15 days from the date of Confirmation Notice.

i. Grace Period: The Plan shall provide The Group with a thirty (30) day grace period that begins on the first day after the last date of paid coverage to make payment of overdue Prepayment Fees to The Plan. During the grace period, coverage will continue. If The Group has not made payment to The Plan by the end of the grace period, The Plan may terminate this Agreement effective on first day after the end of the thirty (30) day grace period.

b. The Plan demonstrates fraud or intentional misrepresentation of material fact under the terms of this Agreement by The Group. Termination shall be effective on the 31st day from the date of notice of cancellation or on the date stated in the notice, whichever is later.

c. Upon 30 days prior written notice in the case The Group breaches this Agreement and fails to cure within the 30 days written notice period.

d. Upon termination, the respective responsibilities of the parties shall be as follows:

i. The Plan shall pay Plan Providers for Covered Services authorized by The Plan prior to termination of this Agreement and rendered after such termination.

ii. As requested in the event of Agreement termination, The Plan shall use its best efforts to assist Members in the transfer of care from Plan Providers to the new plan's contracted providers.

10.4 Payments Due after Termination: In the event of termination of this Agreement by either The Plan (except in the case of fraud or deception in the use of services or facilities of The Plan or knowingly permitting such fraud or deception by another) or The Group:

a. The Plan shall return to The Group, within thirty (30) days, the pro rata portion of the money paid to the Plan which corresponds to any unexpired period for which payment has been received together with amounts due on claims, if any, less any amounts due the Plan.

b. The Group shall make payment of any Prepayment Fees for any period remaining unpaid prior to the effective date of such termination.

10.5 Notice of Termination: Upon receipt of any notice of termination from The Plan, The Group shall inform Subscribers of the termination of this Agreement. The Group shall promptly mail to each Subscriber a legible, true copy of a notice of cancellation and shall provide promptly to The Plan proof of that mailing and the date thereof.

10.6 Notice of Plan Provider Termination: The Plan shall provide written notice to The Group within 30 days in the event that a Plan Provider ceases to be a Plan Provider for The Plan or otherwise becomes unable to provide services, or breaches a contract

with The Plan, if The Group might be materially or adversely affected thereby.

10.7 **Renewal:** This Agreement shall automatically renew for successive one (1) year periods, unless: (1) The Group notifies The Plan in writing 120 days before the end of the contract year of its intent not to renew, or (2) The Group and The Plan, by mutual consent, modify or alter this renewal provision of this Agreement . The Plan shall not increase the amount paid by The Group, nor decrease in any manner the benefits stated in the Agreement, unless written notice of such change has been delivered no less than 120 days prior to this Agreement's renewal effective date.

10.8 **Response to Notice of Plan Termination:** If The Group alleges that the Agreement has been or will be improperly canceled, rescinded or not renewed, The Group may request a review by the director of the Department of Managed Health Care.

11. Warranty and Indemnification

11.1 Responsibility for Own Acts. Each party shall be responsible for its own acts or omissions and for any and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that party or its employees or representatives in the performance or omission of any act or responsibility of that party under this Agreement.

TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW, EXCEPT AS EXPRESSLY PROVIDED IN THE AGREEMENT, NEITHER PARTY MAKES ANY WARRANTY OF ANY KIND, WHETHER EXPRESS, IMPLIED, STATUTORY OR OTHERWISE, AND EACH PARTY SPECIFICALLY DISCLAIMS ALL IMPLIED WARRANTIES, INCLUDING ANY IMPLIED WARRANTY OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE OR NON-INFRINGEMENT. COVERED SERVICES ARE PROVIDED "AS IS" "WHERE IS" EXCLUSIVE OF ANY WARRANTY WHATSOEVER.

11.2 The Group agrees to indemnify, defend, and hold harmless The Plan, its agents, officers, and employees from and against any and all liability expense including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from The Group's performance or failure to perform its obligations hereunder.

11.3 The Plan agrees to indemnify, defend, and hold harmless The Group, its agents, officers, and employees from and against any and all liability expense, including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from The Plan's performance or failure to perform its obligations hereunder.

11.4 Section 11.2 and 11.3 states the indemnifying party's sole liability to, and the indemnified party's exclusive remedy against, the other party for any type of claim described in this Section.

12. Limitation of Liability

12.1 Limitation of Liability. IN NO EVENT WILL EITHER PARTY OR ITS AFFILIATES HAVE ANY LIABILITY ARISING OUT OF OR RELATED TO THIS AGREEMENT FOR ANY LOST PROFITS, REVENUES, GOODWILL, OR INDIRECT, SPECIAL, INCIDENTAL, CONSEQUENTIAL, COVER, BUSINESS INTERRUPTION OR PUNITIVE DAMAGES, WHETHER AN ACTION IS IN CONTRACT OR TORT AND REGARDLESS OF THE THEORY OF LIABILITY, EVEN IF A PARTY OR ITS AFFILIATES HAVE BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES OR IF A PARTY'S OR ITS AFFILIATES' REMEDY OTHERWISE FAILS OF ITS ESSENTIAL PURPOSE. THE FOREGOING DISCLAIMER WILL NOT APPLY TO THE EXTENT PROHIBITED BY LAW. NOTWITHSTANDING ANYTHING TO THE CONTRARY IN NO EVENT SHALL THE AGGREGATE LIABILITY OF EITHER PARTY ARISING OUT OF OR RELATED TO THE CLAIMS DESCRIBED ABOVE IN THIS AGREEMENT, INCLUDING ITS RESPECTIVE AFFILIATES, EXCEED THE TOTAL AMOUNT PAID FOR COVERED SERVICES IN THE TWELVE (12) MONTHS PRECEDING THE FIRST INCIDENT OUT OF WHICH THE LIABILITY AROSE.

13. Individual Continuation of Benefits

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

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

14. Continuity of Care

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

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

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

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

d. If The Plan determines that a Member's treatment should temporarily continue with the Member's existing provider who is a non-Plan Provider, The Plan is not liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provision of services by the existing provider.

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

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

This provision does not apply to providers who were terminated as a Plan Provider

for reasons related to medical disciplinary cause or reason, as defined in Section 805(a)(6) of the California Business and Professions Code, or fraud or other criminal activity.

14.3 The Plan shall pay the non-Plan Provider up to the maximum number of Visits the Member is entitled to under the Benefits Schedule set forth in Attachment A.

14.4 Continuity of Care provisions apply to any covered condition, whether or not acute, serious or chronic in nature.

15. Second Opinions

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

15.2 The Plan will provide an authorization or denial in an expeditious manner appropriate for the nature of the Member's condition.

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

- The reasonableness or necessity of recommendations made is questioned by the Member.
- The indications for treatment are sufficiently complex or confusing that a second opinion may enhance the development of an effective treatment plan.
- The Member has questions about his or her EAP Assessment.
- The Plan Provider is unable to make, or would like additional assistance in making, an EAP Assessment.

15.4 Second opinion consultations are provided at no cost to the Member.

16. General Provisions

16.1 **Notice**: All notices required by this Agreement shall be in writing. Notices shall be sent by either United States mail, certified or registered, or by electronic means, which will be deemed to have the same effect as physical delivery of the paper document, to The Plan or The Group at their respective addresses set forth on the signature page of this Agreement. If mailed in accordance with the above, such notice shall be deemed to be received three business days after mailing. The Group or The Plan shall notify the other party in writing within thirty (30) days of a change of address to which notices are to be sent.

16.2 **Member Non-Liability**: Pursuant to the provisions of the Knox-Keene Act, in the event that The Plan fails to pay a Plan Provider for any sums owed for Covered Services rendered to a Member, the Member shall not be liable in any way to the Plan Provider. In the event The Plan fails to pay a non-Plan Provider for services rendered

to a Member, the Member may be liable to the non-Plan Provider for the cost of the services received.

16.3 **Plan Subject to the Provisions of Knox-Keene Act**: The Plan is subject to the requirements of Chapter 2.2 of Division 2 of the Health and Safety Code and Title 28 of the California Code of Regulations, and any provisions required to be in this Agreement by either of the above shall bind The Plan whether or not provided in this Agreement.

16.4 **Review by the Director of the Department**: If any person believes that a Membership has been improperly canceled, rescinded, or not renewed, or a Member has been denied eligibility or services under the Agreement because of a Member's health status or requirements for EAP benefits, he or she may request a review by the Director of the Department of Managed Health Care of the State of California under section 1365(b) of the California Health and Safety Code.

16.5 **Amendments**: This Agreement may be modified or amended only by a written amendment signed by both parties.

16.6 **No Assignment**: Neither party may assign its rights or delegate its duties under this Agreement without the other party's prior written approval.

16.7 **Attachments and Interpretation**: All Attachments are incorporated into this Agreement at the point of their reference.

16.8 **Governing Law**: This Agreement shall be governed by the laws of the State of California and in particular the Knox-Keene Act and accompanying regulations but without regard to its conflicts of law provisions. Each party agrees that, notwithstanding terms and conditions for Dispute Resolution set forth herein, the exclusive venue for all legal actions related to this Agreement shall be the federal or state court of competent jurisdiction located in Santa Clara County, California.

16.9 **Non-Discrimination**: Neither party may discriminate in any way against any person on the basis of age, sex, race, color, creed, ancestry, physical or mental impairment or handicap, marital status, sexual orientation, or national origin in connection with or related to the performance of this Agreement.

16.10 **Entire Agreement, Prior Agreements**: This Agreement including its Attachments and documents referred to therein represents the entire understanding and agreement of the parties as to those matters contained in it. No prior oral or written understanding shall bring any force or effect with respect to such matters.

16.11 **Severability**: If any provision of this Agreement is determined to be illegal or unenforceable, that provision shall be severed from this Agreement, and the remaining provisions shall remain enforceable between the parties.

16.12 **Waiver**: No waiver of any provision of this Agreement shall be effective against either party unless it is in writing and signed by the party granting the waiver. Failure to exercise any rights shall not operate as a waiver of such right.

16.13 Authority to Execute: By their signature below, each of the following persons represent that they have the authority to execute this Agreement and to bind the party on whose behalf their execution is made.

17. Dispute Resolution

17.1 Grievance Procedure: The Plan shall establish and maintain grievance procedures, and shall provide The Group with said procedures for dissemination to Members. Those procedures shall include the current address and telephone number for registering grievances with The Plan, including the availability of a grievance form and a description of procedures for filing a grievance online through the Plan's website. For purposes of this section, complaint shall have the same meaning as grievance.

a. The Plan maintains a Quality Improvement Committee comprised of the Medical Director, who chairs it, two Plan Providers and two staff. The Committee shall provide supervision over, and review grievances not resolved by, The Plan's Medical Director and Clinical Manager. The Committee shall have primary responsibility for the review of the grievance procedures, and for the analysis of any patterns that could impact policy changes and procedural improvements in The Plan's administration.

b. A Member may file a complaint form about The Plan's services or that of a Plan Provider by appearing in person or writing or calling The Plan, at:

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

info@concernhealth.com

Grievances may also be filed through the Plan's website at www.concernhealth.com, or faxed to the Plan at **650-934-2310**.

Complaint forms and copies of the grievance procedure shall be available at The Plan's office and at each Plan Provider office as well as on the Plan's website. In addition, complaint forms shall be sent to Members on request. Completed forms should be submitted to the above address or through procedures noted on the website. Assistance will be provided by a Plan representative to anyone attempting to file a grievance in person or by telephone.

c. Members will receive a written response within five (5) calendar days acknowledging receipt of the complaint, and within thirty (30) calendar days a written notice describing the Plan's resolution of the complaint. Grievances that require expedited review will be resolved

within three (3) calendar days. The details of these processes will be outlined in the Evidence of Disclosure and Coverage Form (EOC).

i. A written record shall be made of all grievances received, whether in person, by mail or email, by fax or by telephone, or through the website, including the date, the name of the person recording the complaint, a summary describing the grievance, and the resolution. The Clinical Manager will tabulate the types and numbers of grievance received for periodic review by The Plan's Board of Directors, the Public Policy Committee, the Quality Improvement Committee and Chief Executive Officer in connection with their consideration and formation of The Plan's policy. The Quality Improvement Committee shall include in its periodic reports recommended corrective actions to be taken in light of the pattern of grievances received.

ii. The Plan will assure that a Member is not discriminated against for having filed a complaint. The Quality Improvement Committee will investigate any alleged retaliation and take appropriate action.

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

17.3 Review by the Department of Managed Health Care: 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 this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

17.4 Arbitration of Disputes:

a. In addition to the Grievance Procedure, a Member may also seek redress by submitting the dispute to binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association. Binding arbitration is the final process for resolution of any dispute described in section 16.4.b. below. Under binding arbitration, both parties give up their rights to have the dispute decided by jury in a court of law.

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

c. The Member seeking binding arbitration shall send a written notice to The Plan. The notice shall contain a demand for binding arbitration and a statement describing the nature of the dispute, including the specific issue(s) involved, the amount involved, the remedies sought and a declaration that the party seeking binding arbitration has previously attempted to resolve the dispute with The Plan. For further assistance, the Member may also write to the AAA at 3055 Wilshire Blvd., 7th Floor, Los Angeles, CA 90010-1108, or telephone **(213) 383-6515**.

d. In the case of extreme economic hardship, a Member may request from The Plan information on how to obtain an application for full or partial assumption of the Member's share of fees and expenses incurred by the Member in connection with the arbitration proceedings.

e. For all claims or disputes for which the total amount claimed is $200,000 or less, the parties shall select a single neutral arbitrator who shall have no jurisdiction to award more than $200,000. This provision is not subject to waiver, except nothing in this section shall prevent the parties from mutually agreeing, in writing, after a case or dispute has arisen and a request for arbitration has been submitted, to use a tripartite arbitration panel which includes two party-appointed arbitrators or a panel of three neutral arbitrators, or another multiple arbitrator system mutually agreeable to the parties. The agreement

shall clearly indicate, in boldface type, that "A case or dispute subject to binding arbitration has arisen between the parties and we mutually agree to waive the requirement that cases or disputes for which the total amount of damages claimed is two hundred thousand dollars ($200,000) or less be adjudicated by a single neutral arbitrator." If the parties agree to waive the requirement to use a single neutral arbitrator, the Member or Subscriber shall have three business days to rescind the agreement. If the agreement is also signed by counsel of the Member or Subscriber, the agreement shall be binding and may not be rescinded. If the parties are unable to agree on the selection of a neutral arbitrator, The Plan shall use the method provided in section 1281.6 of the Code of Civil Procedure to select the arbitrator.

f. The parties agree that the arbitrator(s) shall issue a written opinion, and the award of the arbitrator shall be binding and may be enforced in any court having jurisdiction thereof by filing a petition of enforcement of said award. The findings of the arbitrator and the award of the arbitrator issued thereon shall be governed by the applicable state and federal statutory and case law. The arbitrator's award shall be accompanied by a written decision explaining the facts and reasons upon which the award is based, including the findings of fact and conclusions of law made and reached by the arbitrator(s). The decision shall be signed by the arbitrator(s) in order to be effective.

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

h. The arbitrator(s) shall make the necessary arrangements for the services of an interpreter upon the request of any party, which party shall assume the cost of such services.

i. The arbitration shall take place in the largest city or town in the county where the services were provided, unless some other location is mutually agreed upon by the parties, and shall be governed by the rules of the American Arbitration Association. The expenses of the arbitrator(s) shall be shared equally by the parties.

Signatures on next page

//

//

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date set forth above.

CONCERN: Employee Assistance Program

Name Sign: DocuSigned by: Cecile Currier DFC544DF1FBA4FD...

Name Print: Cecile Currier

Title: CEO

Date: 7/14/2023

Monterey Bay Area Self-Insurance Authority

Name Sign:

Name Print: Conor Boughey

Title: MBASIA Program Administrator

Date: 7/14/2023

CONCERN: EAP Headquarters
2490 Hospital Drive, Suite 310
Mountain View, CA 94040
(800) 344-4222

Monterey Bay Area Self-Insurance Authority
560 Mission Street, 6th Floor
San Francisco, CA 94105

Attachment A

COVERED SERVICES

BENEFIT SCHEDULE

The Plan shall provide the following Covered Services:

A. EAP Assessment, referral to community resources and Medical Emergency Care, and short-term counseling. The Plan offers counseling services for a wide range of personal problems and immediate response for Crisis situations. Each First Responder Member and his or her Covered Dependents shall be limited to a maximum of **Ten (10) Visits** for each problem. Counseling for First Responders will be provided by counselors on a First Responder Specialty Panel. Counseling for Covered Dependents of First Responders will be provided from our standard panel of counselors or by counselors on a First Responder Specialty Panel when appropriate. Each Non-First Responder Member and his or her Covered Dependents shall be limited to a maximum of **Five (5) Visits** for each problem per twelve-month, beginning with the date of the case opening. Counseling will be provided from standard panel of counselors. For the purpose of this provision, the word "problem" means a specific type of matter, situation or issue of concern to a Member for which the Member requests EAP services for purposes of obtaining assistance in arriving at a solution. If a Member is referred for unsatisfactory work performance by means of a Supervisor Referral, or if a Member or Covered Dependent is assessed as having a chemical dependency problem, the maximum number of visits shall be **Ten (10)**. The Plan provides counseling for "problem" issues including but not limited to:

   (i) marital and family problems,

   (ii) difficulty with relationships,

   (iii) emotional distress,

   (iv) job stress,

   (v) communications or conflict issues,

   (vi) substance abuse issues and

   (vii) loss and death issues.

B. The Plan provides a problem-focused form of individual or family outpatient counseling that

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

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

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

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

C. The Plan offers Parent Coaching free of charge. This benefit includes three (3) telephonic sessions per year with an experienced professional for parents to get help with their children's emotional wellbeing.

D. 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 refer Members to individuals who provide parenting and childcare resources, adult care resources, legal consultations, and financial services.

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

F. 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 by The Plan and the Plan Provider that the Member is responsible for payment of costs and fees for services provided.

G. The Plan Provider shall also obtain from a Member a consent form prior to the release of any information concerning said Member, except as required by law. A Plan Provider shall explain such form to each Member.

H. Upon request, The Plan shall provide (16) hours per contract year of on-site or virtual educational seminars and crisis response. Seminars are to be selected from a list of topics provided by The Plan. Cancellations of educational seminars within three business days of their scheduled time shall be counted as used on-site or virtual hours, or subject to a late cancellation billing of Four Hundred Fifty Dollars ($450), whichever applies. Additional hours may be purchased by The Group at current pricing.

I. The Plan shall conduct management orientation sessions for The Group's management and supervisory personnel and employee orientation sessions for The Group's personnel at such times and locations as are mutually agreed upon by The Plan and The Group.

J. Upon request, The Plan shall consult with The Group's Human Resources staff and individual supervisors and managers regarding potential or actual supervisory referrals and Employee performance issues.

K. The Plan shall provide quarterly and annual reports. Such reports shall include statistics on number of Employees using The Plan, demographics, referral sources, services used and problem types.

L. Facilities: The Plan's Provider's offices are located close to where member work or live, and are available during regular business hours. To find out the exact address and hours of operation of a Plan Provider's office, contact The Plan at **(800) 344-4222.** Member will be asked to provide either the city or zip code where member would like to receive care.

M. The Plan shall provide members with access to the digital platform, a digital guide to customized care recommendations that include; an online assessment, triage to appropriate level of care based on risk, a personalized dashboard, client-counselor matching for face-to-face or video counseling, work/life referrals and resources, self-guided content, and digital therapeutics.

Attachment B

FEE SCHEDULE

B.1 Fees.

i. For First Responder, the Group shall pay nine dollars and fifty cents ($9.50) per Employee per month for Covered Services, August 1, 2023 to July 31, 2025.

ii. For Non-First Responder, the Group shall pay four dollars and thirty cents ($4.30) per Employee per month for Covered Services, August 1, 2023 to July 31, 2025.

B.2 Invoices. The Plan will invoice The Group monthly based on an accurate headcount of all Employees covered by The Plan, to be provided by The Group at the beginning of each month. All amounts due under this Agreement shall be paid to The Plan within 30 days of invoice date. In the event that payment is not received within 30 days of invoice date, a finance charge of 1.5% (18% annually) will be applied.

Payment shall be remitted to:

CONCERN: EAP
P.O. Box 883079
Los Angeles, CA 90088-3079

Payment via ACH instructions:
Bank: Wells Fargo Bank, N.A.
Account Name: CONCERN: EAP
Account Number: 4375669967
Routing & Transit Number: 121000248
Notification Email: billing@concernhealth.com

Tax I.D. number for The Plan is 77-0528349.

For questions or changes, please contact the Plan at billing@concernhealth.com

Attachment C

BETA HEALTHCARE GROUP
BETA RISK MANAGEMENT AUTHORITY

CERTIFICATE OF COVERAGE

Named Member:
Concern: Employee Assistance Program
c/o El Camino Hospital 2500 Grant Road
Mountain View, CA 94040

Insuring Company:
BETA Risk Management Authority
P.O. Box 619084
Roseville, CA 95661

This document certifies that coverage is in force for the Named Member on the Issue Date below, subject to the terms and conditions of the Contract designated. It is issued as a matter of information and does not confer any rights to any Certificate Holder. This Certificate does not amend, extend or alter the coverage afforded under the Contract. If the Contract, or coverage for any Member, is canceled for any reason or if the terms of the Contract are changed, we will notify the Named Member only. Coverage is not in effect unless and until all payments are received when due.

Certificate Number	Effective Date	Expiration Date	Retroactive Date *
HCL-23-078	07/01/2023 at 12:01 a.m.	07/01/2024 at 12:01 a.m.	01/01/1993 at 12:01 a.m.

Type of Coverage:

[X] Professional Liability - Claims Made and Reported

[X] General Liability - Occurrence

Limits of Liability:		Deductible:	
$10,000,000	Per Claim	$1,000	Per Claim
$20,000,000	Aggregate Per Contract Period	NONE	Aggregate Per Contract Period

Description of Coverage:
Evidence of Healthcare Entity Professional Liability, Bodily Injury & Property Damage Liability, Personal Injury and Advertising Injury Liability, and Employee Benefit Liability coverage

Issue Date: May 25, 2023

Certificate Holder:
FOR INFORMATION ONLY

Authorized Representative:
Michele D. Reager

Michele D. Reager, CPCU
Vice President of Underwriting

* the retroactive date applies to claims made coverage only

Attachment D
CITY MEMBERS

- City of Capitola
- City of Del Rey Oaks
- City of Gonzales
- City of Greenfield
- City of Hollister
- City of King City
- City of Marina
- City of Sand City
- City of Scotts Valley
- City of Soledad