*SOUTHERN CALIFORNIA CONFERENCE*

Employee Assistance Plan (EAP)

# 2026 COUNSELING FOR ELIGIBLE WORKERS

In order to assist workers who are enrolled in our health-care plan, Southern California Conference (SCC) has adopted the following Employee Assistance Plan (EAP) for counseling services. If the treatments are coverable by Blue Shield of California Mental Health, the worker should file a claim with Blue Shield in order to maximize the benefits available. Benefits are subject to plan deductible and will be reimbursed per current deductible reimbursement policy.

For therapies not covered by Blue Shield of California the following reimbursement policy will apply.

1. EAP Benefits:
    a) Maximum limit payable for counseling sessions per calendar year is $3,600.00 per covered person; and
    b) 80% of the cost per visit/treatment.
2. Qualifications and Pre-requisites:
    a) Must be enrolled in the SCC Blue Shield medical plan;
    b) Provider must be a licensed counselor and provide the counselor's state license number and expiration date;
    c) The Provider must present a written treatment plan. (**The counselor ***MUST*** ***NOT*** disclose any diagnosis or details of the issues**);
    d) The Provider must indicate the per visit/plan charges;
    e) The worker must acknowledge receipt, understanding and agreement to this EAP by signing and dating this description below).
3. Conditions for reimbursement:
    a) Worker must submit receipts from the provider showing payments made, including dates of service and payment;
    b) Receipts must be submitted to SCC Human Resources processing agent (flex.10003@trucordia.com) as soon a reasonably possible.

NO CLAIMS FOR 2026 WILL BE ACCEPTED AFTER MARCH 31, 2027

I, _____, (printed name of worker), have read, understand and agree with the above-described terms and conditions of the SCC Employee Assistance Plan/ Counseling. *This signed policy acknowledgement form is to be submitted to processing agent along with appropriate documentation, Claim form, Blue Shield of California EOB or Treatment Plan and invoice.*

_____ _____

Signature of worker Date