HOLMAN PROFESSIONAL COUNSELING CENTERS
GROUP CONTRACT
SUPPLEMENTAL MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

This Agreement is made by and between, **HOLMAN PROFESSIONAL COUNSELING CENTERS,** (hereinafter "HPCC") a California corporation having its principal place of business at P.O. Box 8011, Canoga Park, CA 91309, telephone number (800) 321-2843, and **MIRACOSTA COLLEGE** (hereinafter "Employer") hereby enter into this Group Plan Contract as of this July 1, 2023.

RECITALS

A. Holman provides Employee Assistance Program Services (not a covered benefit) and a full range of inpatient, outpatient, Day Care and Substance Related Treatment Services to employees and their eligible dependents, while at the same time maintaining the requisites of an independent and responsible profession; and

B. Holman desires to enter into this Agreement to render covered services to Employer Enrollees pursuant to this Agreement.

C. Employer desires to enter into this Agreement to have Holman render covered services to its enrollees pursuant to this Agreement.

D. This Agreement incorporates by reference all exhibits mentioned and attached, including but not limited to, the Supplemental Mental Health and Substance Abuse Services Benefit Schedule (Exhibit A), the Benefit Schedule and Disclosure Statement (Exhibit B), and the Rate Information (Exhibit C).

AGREEMENT

1.0 DEFINITIONS

1.1 Acute Condition. A medical condition of limited duration that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention.

1.2 Acute Hospital: Health facility with a medical staff that provides 24-hour inpatient care for substance abuse patients.

1.3 Authorization/Authorized: A decision, issued verbally and in writing by the Holman Medical Director or his /her designee, that benefits are payable for certain services that an enrollee will receive or has received.

1.4 Benefits Schedule: (Attached as Exhibits A and B) Describes the available levels of treatments provided through a Group Plan Contract, along with required deductibles and copayments.

1.5 Contracted Provider: A person licensed as a psychiatrist, psychologist, clinical social worker, marriage and family therapist, nurse, or other licensed health care professional with appropriate training and experience in behavioral health services, and who has contracted with Holman to deliver specified services to Holman enrollees.

1.5.1 A marriage and family therapist means a licensed marriage and family therapist who has received specific instruction in assessment, diagnosis, prognosis and counseling, and psychotherapeutic treatment of premarital, marriage, family, and child relations dysfunctions, which is equivalent to the instruction required for Licensure on January l, 1981.

1.5.2 Professional clinical counselor means a licensed professional clinical counselor who has received specific instruction in assessment, diagnosis, prognosis, counseling and psychotherapeutic treatment of mental and emotional disorders, which is equivalent to the instruction required for licensure on January 1, 2012.

1.6 Coordination of Benefits: The allocation of financial responsibility between two or more insurance companies or health care providers, each with a legal duty to pay for covered services provided to an enrollee at the same time.

1.7 Copayment: Fee paid to a provider by an enrollee at time of provision of covered services. Such fees may be a specific dollar amount or a percentage of total fees, depending on the type of services provided.

1.8 Coverage Decision: The approval or denial of health care services by a plan, or by one of its contracting providers, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the te1ms and conditions of the health care service plan contract. The criteria used to determine whether to authorize, modify, or deny health care services are developed with the involvement from actively practicing health care providers, consistent with sound clinical principles and processes and are evaluated and updated, if necessary, at least annually. These criteria are available to the public upon request. The materials provided to enrollees are guidelines used by the Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under this contract. Upon enrollee request, Holman will disclose its processes, including criteria and guidelines, for authorizing, modifying or denying services.

1.9 Day Care Supplemental Mental Health and Substance Abuse Services: Includes the full range and scope of inpatient Mental Health and Substance Abuse Services, at both hospitals and facilities, except that the Enrollee stays overnight in a place other than the hospital or facility, usually the enrollee's home.

1.10 Disputed Health Care Service: Any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary.

1.11 DRG: Diagnosis Related Group: A patient classification system describing the case mix and type of patient a hospital treats. It is used to reimburse hospitals for services provided.

1.12 Eligible Dependents: Includes Eligible Enrollee's lawful spouse, domestic partner (as defined in Section 297 of the Family Code) and children to age 26. Children include stepchildren, adopted children, and foster children, provided such children are dependent upon the Member for support and maintenance. Coverage for each child placed for adoption immediately begins from and after 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 release report, a medical authorization form, or a relinquishment form, granting the subscriber or spouse the right to control health care for the adoptive child. Attainment of the limiting age of 26 by children, shall not operate to terminate the coverage of a child while the child is and continues to be incapable of self--sustaining employment by reason of physical or mental condition (ce1tified by a doctor in writing), the child is chiefly dependent upon an Eligible Enrollee for support and maintenance.

1.13 Eligible Employee: Employee of Employer who is eligible for benefits by Employer pursuant to Employer's obligations under this Group Plan Contract. Employees enrolled in the Kaiser medical plan are eligible to use the Supplemental Mental Health and Substance Use only plan and upon termination of employment, are covered through the last day of the month. Continuation of Coverage on the Supplemental Mental Health and Substance Use only plan will be allowed as specified by COBRA provisions.

1.14 Emergency: The sudden onset of severe Supplemental Substance abuse symptoms and impairment of functioning due to chemical dependency such that the absence of immediate attention could reasonably be expected to result in any of the following:

1.14.1 Enrollee's health is placed in serious jeopardy;

1.14.2 Serious impairment to bodily functions;

1.14.3 Serious dysfunction to any bodily organ or part.

1.15 Emergency Mental Health and Substance Abuse Services and Care: Includes the 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 an emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the substance use diagnosis emergency medical condition, within the capability of the facility.

1.16 Employee Assistance Program Services ("EAP"): A program of comprehensive assessment, short term treatment and referral services designed to identify and make appropriate referrals for treatment of physical, mental or emotional conditions which may result in impaired enrollee performance. **(Not covered under this agreement)**.

1.17 Employer: An organization that has contracted with Holman to provide Supplemental Mental Health and Substance Abuse Services to its Eligible Employees.

1.18 Enrollee: An Eligible Enrollee (and/or such Eligible Enrollee's eligible dependents) of an Employer who has contracted with Holman to provide coverage for Supplemental Mental Health and Substance Abuse Services. Enrollee must meet Holman's eligibility requirements, enroll in the Employer's Group Plan, and accept the financial responsibility for any copayments that may be incurred in treatment through the Holman Plan.

1.19 Evidence of Coverage and Disclosure Form Combined: Brochure issued to an enrollee setting forth the coverage to which the enrollee is entitled and describing the procedure through which Holman furnishes care.

1.20 Family Unit: Comprised of enrollee plus enrollee's eligible dependents for the EAP only.

1.21 Fraud: The deliberate submission of false information by a provider, enrollee, plan Member, or other individual or entity, to gain an undeserved payment on a claim.

1.22 Group: The entity with which the Health Plan has entered into the Agreement.

1.23 Group Plan Contract: Agreement between an Employer and Holman providing that Holman will provide Supplemental Mental Health and Substance Abuse Services for the Employer's eligible enrollees in exchange for Premiums paid by the Employer to Holman.

1.24 Group Therapy Session: Goal oriented mental health services provided in a small group setting by a Holman provider. Group Therapy Sessions can be made available to the enrollee in lieu of individual outpatient therapy when appropriate.

1.25 Hospital: A health care facility including any acute care hospital or acute facility that has entered into a contract with Holman to deliver a full range of Supplemental Mental Health and Substance Abuse Services on an inpatient treatment basis.

1.26 Inpatient Services: Supplemental Mental Health and Substance Abuse Services provided on a 24-hour basis at a Hospital including all procedures utilizing psychological principles and methods for the understanding, diagnosis, and treatment of Enrollees with emergency and medically necessary mental health conditions, alcohol, chemical dependence, or substance abuse.

1.27 Language Assistance Program: Plan shall establish and maintain an ongoing language assistance program to ensure Limited English Proficient ("LEP"). Enrollees have appropriate access to language assistance while accessing health care services as required by the Language Assistance Program Regulations. Provider shall cooperate and comply, as applicable, with Plan's language assistance program; however, Holman shall maintain ongoing administrative and financial responsibility for implementing and operating on an ongoing basis the language assistance program for enrollees.

1.28 Letter of Agreement: A contract entered by Holman and a previously non-contracted licensed provider to deliver services on an emergency only basis.

1.29 Life Threatening Illness: Includes 1) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; or 2) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

1.30 Medical Detoxification: Medically based supervised treatment for an unstable or acute medical condition resulting from withdrawal from chemical substances including drugs or alcohol.

1.31 Medically Necessary: Except were state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean mental health or substance related disorder services that a Licensed Mental Health Professional exercising prudent clinical judgment would provide to an enrollee for the purpose of evaluating, diagnosing, or treating a mental or substance related disorders that are:

Appropriate and necessary for the diagnosis or treatment of the condition within standards of good clinical practice within the substance related treatment community, clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the enrollee's condition.

1.32 Non-Contracted Provider: Any provider not contracted with Holman to deliver services to enrollees. Every effort will be made to assure enrollees are not subject to balance billing practices for services paid under the Holman Agreement. Enrollees may be liable for the cost of non-emergency services provided by non-contracted providers.

1.33 Outpatient Services: Outpatient Supplemental Mental Health and Substance Abuse Services are those services that are provided by a provider in his or her office or appropriate outpatient setting.

1.34 Premium: Pre-determined monthly membership fee paid by an Employer for coverage under the Group Plan Contract.

1.35 Prior Authorization: Approval of coverage from Holman prior to the enrollee obtaining covered services. Requests for prior authorization will be denied if not Medically Necessary, if in conflict with Holman's policies or otherwise are not covered services.

1.36 Private Therapy Session: A private session consists of one enrollee with a provider (rather than a Group Therapy Session) and includes:

1.36.1 A 45-50minute consultation as treatment needs dictate.

1.36.2 A 45-50minute psychological assessment and referral.

1.36.3 The administering of standardized tests, including time involved in scoring and interpretation.

1.36.4 A 30-45minute unit of time to facilitate the admission of an enrollee.

1.37 Provider: A person licensed as a psychologist, psychiatrist, clinical social worker, marriage and family therapist, licensed professional counselor, registered associate therapist, nurse, other licensed health care professional or qualified autism service provider, professional or paraprofessional with appropriate training and experience in Behavioral Health Services, working individually or within a corporation, clinic, or group practice, who is employed or under contract with Holman to deliver behavioral health services to enrollees.

1.38 Serious Chronic Condition: 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:

1.38.1 Persists without full cure or worsens over an extended period of time;

1.38.2 Requires ongoing treatment to maintain remission or prevent deterioration.

1.39 Serious Debilitating Illness: Diseases or conditions that cause major irreversible morbidity.

1.40 Sub-Acute Care Facility: Any state licensed substance abuse community residential treatment facility that has entered into a provider agreement with Holman to deliver the full range of community residential treatment services, both on an inpatient basis and on a day care basis. Referral of enrollees to a facility shall be made, where appropriate, as an alternative to hospital care.

1.41 Subscriber: Person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

1.42 Supplemental Mental Health and Substance Abuse: Services include all procedures utilizing psychological principles and methods for the understanding, diagnostic, referral, prevention, and treatment of substance abuse issues in adults, children, couples, and families. Procedures utilized may include, but are not limited to, individual counseling, group or family counseling, chemical and alcohol abuse counseling, and hypnosis, used in a professional relationship to assist a person or persons to acquire greater human effectiveness, or to modify feelings, work situations, conditions, attitudes, and behavior which are emotionally, intellectually, or socially ineffectual or maladjusted.

1.43 Treatment Plan: A written clinical presentation of the provider's diagnostic impressions and therapeutic intervention plans. The Mental Health or Substance Related Treatment Plan is submitted routinely to Holman for review as part of the concurrent review monitoring process.

1.44 Urgently Needed Mental Health and Substance Abuse Services: Medically Necessary Behavioral Health Services required outside of the service area to prevent serious deterioration of an enrollee's behavioral health resulting from a sudden onset of illness or injury manifesting itself by acute mental health or substance related symptoms of sufficient severity, such that treatment cannot be delayed until the enrollee returns to the service area.

1.45 Utilization Management Committee (UMC): A committee operating within Holman whose function is to ensure both quality and cost-effectiveness of treatment.

1.46 Visit Outpatient: An outpatient session with a provider conducted on an individual or group basis during which Mental Health or Substance Abuse Services are delivered.

2.0 COVENANTS OF EMPLOYER

2.1 Premium: Employer agrees to pay Holman an initial monthly Premium, due at the end of the month for the month due (July), for this Group Plan Contract, and thereafter at the end of the month for the month due, the sum (outlined on Exhibit C of this contract) for each eligible enrollee to be covered pursuant to this Group Plan Contract. These payments will be facilitated through an electronic fund transfer mechanism. Calculation of the premiums will be determined by using the previous month's eligibility list; as a result, premium reconciliation will trail by one month.

2.2 Enrollee Count. Employer agrees to furnish to HPCC, on or prior to the first day the effective date of this Group Plan Contract, an enrollee count on the monthly invoice of all persons who shall be Eligible Enrollees under this Group Plan Contract.

2.3 Enrollment Provisions: Enrollment will be facilitated by the primary health plans. Any eligible enrollee under any of the pertinent medical health plans (Kaiser Permanente) will be considered an eligible enrollee.

2.4 Required Distribution: Employer agrees to distribute to all enrollees copies of the Combined Evidence of Coverage/Disclosure Form for EAP and Supplemental Substance Abuse benefits as provided by Holman. Employer also agrees to disseminate any materials supplied by Holman, in accordance with legal or contractual requirements, to its enrollees by its next regular communication to eligible employees, but in no event later than thirty (30) days after receipt by Employer. Additionally, if an enrollee requests a copy of the Group Contract from the Employer, the Employer will provide such copy.

2.5 Required Employer Notice to Enrollees: Employer shall direct enrollees who wish to receive Services to telephone Holman at (800) 321-2843 or Employer/Enrollees can also

visit www.Holmangroup.com, User Name: MiraCostaCollege & Password: MCC7123. Provider search and list of Holman contracted providers/facilities is available on our website homepage without a password. Once a Holman contracted provider has been selected from the Holman website, Holman must be called and informed of the provider's name by the Provider/Enrollee.

2.5.1 Written notice of cancellation of enrollment according to Section 2.7.

2.6 Required Employer Notifications to HPCC. Employer shall notify HPCC in writing within thirty (30) days of any enrollee who has had one of the following qualifying events:

2.6.1 Death of an Eligible Employee;

2.6.2 Termination of employment, (except that termination for gross misconduct does not constitute a qualifying event);

2.6.3 Divorce or legal separation of the Eligible Employee from the covered Employee's spouse;

2.6.4 Loss of dependent status by a dependent enrolled in the group benefit plan;

2.6.5 With respect to a covered dependent only, the Eligible Employee's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

Employer shall notify HPCC in writing within thirty (30) days of the date when Employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employment Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq.

2.7 Plan Cancellation Notification. In the event of the cancellation of the Group Plan Contract, HPCC shall notify the Employer in writing 90 days prior to the effective date of the cancellation. The group contract holder shall then promptly mail to each Enrollee a legible, true copy of the notice of cancellation of the contract received from the Plan. It is the responsibility of the Employer to notify the enrollee of the termination of this agreement.

2.8 Notice of Cancellation for Non-Payment of Premiums and Grace Period. In the event HPCC provides notice of cancellation for non-payment of premium to the Employer, Employer agrees to promptly mail a legible, true copy of the notice of cancellation to all subscriber/enrollee at their current address. The notice of cancellation to Employer will include:

- Effective date of the cancellation and grace period; the date of the last day of paid coverage

- The reason for cancellation, including reference to the applicable clause in this Agreement

- The dollar amount due to HPCC

- The date the grace period begins and expires. Grace period means a period of at least 30 days beginning no earlier than the first day after the last date of paid coverage to allow the Employer to pay an unpaid premium amount without losing healthcare coverage. At a minimum this grace period shall extend through the thirtieth (30^{th}) day after the last date of paid coverage.

- The obligations of the enrollee or group contract holder during the grace period (if any)

- A statement that the cause for cancellation was not due to the enrollees health status or requirements for health services

- A clear and concise explanation of the right to submit a Request for Review to the Director including the language provided in subdivision 1300.65(c)(6) of the California Code of Regulations, Title 28.

- That an enrollee who alleges that cancellation was due to the enrollees health status may request a review of cancellation by the Department of Managed Health Care

- Information regarding the enrollees COBRA, Cal-COBRA, conversation coverage and HIPAA individual coverage.

The notice of cancellation for nonpayment of premiums and grace period shall be sent no later than 5 business days after the last day of paid coverage. The notice of cancellation for nonpayment of premiums and grace period shall include the language in California Title 28, Section 1300.65(c)(3)(B)(ii) in be in at least 12-point font:

"You are receiving this Notice of Cancellation because your HPCC coverage is being cancelled or not renewed because you have not paid your premium. Even though you have not paid your premiums, you are being provided a "grace period" to allow you time to make your past due premiums payment(s) without losing your health care coverage. "Grace period" means a period of at least 30 days beginning no sooner than the first day after the last day of paid coverage and lasts at least 30 days. Your grace period ends on (insert month, day, year). You may avoid losing your coverage if you pay the premium(s) owed to HPCC before the end of the grace period. If you do not pay the required premium amount by the end of the grace period, your coverage will be terminated effective the day after the last day of the grace period. Your grace period ends on (insert month, day, year). Coverage will continue during the grace period; however, you are still responsible to pay unpaid premiums and any copayments, coinsurance or deductible

amounts required under the plan contract. For information about individual health care coverage and health care subsidies that may be available to you, contact Covered California at (800) 300-1506 or TTY at (888) 889-4500 or online at www.CoveredCa.com. If you wish to end your coverage immediately, please contact HPCC as soon as possible."

The Employer shall also provide proof of the mailing and the date thereof to HPCC by way of a signed attestation within 3 days of such mailing. In the event the Employer fails to comply with this condition, coverage will be extended until such time HPCC can comply with the mandated notice requirements. In the event that HPCC cancels the Group Plan Contract, other than for non-performance by the Employer, HPCC will comply with the mandated notice requirements and cover the costs for such mailing described in this section.

After 24 months following the issuance of this group contract, HPCC shall not rescind this group contract for any reason, and shall not cancel the group contract, limit any of the provisions of the group contract, or raise premiums on the group contract due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.

In the event that HPCC withdraws from the market, HPCC will notify the Employer, all enrollees and the Director at least 90 days prior to the discontinuation. If HPCC withdraws a health benefit plan from the market, HPCC will notify the Employer, enrollees and the director at least 90 days prior to the discontinuation of the group contract. Notice of the decision to cease new or existing health benefit plans in the state is provided to the director, the Employer and the enrollees covered under this group plan contract at least 180 days prior to the discontinuation of this contract. HPCC will notify the employer to promptly send the notice listed in 2.8 to the enrollees.

2. 9 Notification of Continuation Coverage to Enrollees: Employer shall notify enrollees currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the enrollee would have remained covered as specified in Section 1366.27 of the California Health and Safety Code, of the enrollee's ability to continue coverage under a new group benefit plan for the balance of the period the enrollee would have remained covered under the prior group benefit plan. This notice shall be provided either thirty (30) days prior to the termination or when all enrollees are notified, whichever is later.

2.10 Notification of Continuation Coverage to Successor Group Benefit Plan: Employer shall notify the successor group benefit plan in writing of the qualified enrollees currently receiving continuation coverage so that the successor plan, or contracting Employer or administrator, may provide those enrollees with the necessary Premium information, enrollment fo1ms, and instructions consistent with the required disclosure in order to allow the enrollee to continue coverage.

2.11 Notice of Consequences for Nonpayment of Premiums means notice sent by HPCC to the Employer that this group contract will be cancelled, rescinded or not renewed unless the premium amount due is received by HPCC no later than the last day of the Grace Period. Should there be a nonpayment of premiums by the Employer to HPCC, HPCC will send the Employer a notice of consequences for nonpayment of premiums.

2.12 Notice of Cancellation, Rescission or Nonrenewal means the notice sent by Holman to the Employer that this group contract will be cancelled, rescinded or not renewed for any reason other than non-payment of premiums as pe1mitted under Health and Safety Code 1365 or Section 1300.65. The Notice will be sent by Holman to the Employer to promptly send the Notice to the enrollees. The language of the notice must be in at least 12-point font with the language listed in California Title 28, Section 1300.65(c)(6):

"Right to Submit Request for Review of Cancellation, Rescission, or Nonrenewal of Your Plan Contract, Enrollment, or Subscription. "

If you believe your plan coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a Request for Review.

You have the options of going to the plan and/or the Department if you do not agree with the plan decision to cancel, rescind or not renew your plan coverage.

Option (1) - You may submit a Request/or Review to your plan.

**You may submit a Request for Review to Holman by calling 1-800-321-2843 or submitting a request at www.HolmanGroup.com. or by mailing your written Request for Review to Holman, PO Box 8011, Canoga Park, CA 91303.*

** You may want to submit your Request/or Review to Holman first if you believe your cancellation, rescission or nonrenewal is the result of a mistake. Requests for Review should be submitted as soon as possible after you receive the Notice of Cancellation, Rescission, or Nonrenewal.*

**Holman will resolve your Request for Review or provide a pending status within three (3) days. If the plan upholds your cancellation, rescission or nonrenewal, it will immediately transmit your Request for Review to the Department of Managed Health Care and you will be notified of the plan's decision and your right to also seek a further review of the plan's decision by the Department as detailed under*

Option 2, below.

Option (2) - You may submit a Request for Review to the Department of Managed Health Care.

** You may submit a Request for Review directly to the Department of Managed Health Care without first submitting it to the plan or after you have received the plan's decision on your Request for Review.*

**Requests for Review by the Department of Managed Health Care may be submitted:*

By mail:

HELP CENTER

DEPARTMENT OF MANAGED HEALTH CARE 980 NINTH STREET, SUITE 500

SACRAMENTO, CALIFORNIA 95814-2725

BY PHONE:

1-888-466-2219

TDD: 1-877-688-9891

FAX: 1-916-255-5241 OR ONLINE:

WWW.HEALTHHELP.CA.GOV"

2.13 Employer: Employer agrees that Holman may use Employer name as a subscribing group in any of HPCC's advertising or other promotional literature.

3.0 COVENANTS OF HPCC

3.1 Provision of Services: Holman shall provide Supplemental Mental Health and Substance Abuse services through providers pursuant to the Schedule of Benefits. If an enrollee wishes to use a contracted provider, such enrollee shall telephone HPCC at (800) 321-2843. HPCC will then assign the enrollee to an appropriate contracted provider based upon intake information that HPCC will request in its telephone conversation with the enrollee. Enrollee can log into www.HolmanGroup.com (User Name: MiraCostaCollege & Password: MCC7123. Once a HPCC contracted provider has been selected from the Holman Website, Holman must be called and informed of the provider's name by the "Company Name" enrollee. If the enrollee wishes to use a non-contracted provider, enrollee would do so at his or her own expense, except as otherwise provided in this Group Plan Contract, and it shall be the responsibility of the enrollee to arrange for services to be rendered with the non-contracted provider. Emergency services will be available on a 24-hour-per-day, 7-day-per-week basis. Inpatient and day care services

shall be provided by Hospitals or Sub-Acute Care Facilities under contract with the Plan. Emergency services do not require pre-authorization.

3.2 Additional Services: In addition to Behavioral Health Services, Holman also provides legal and financial counseling referrals to its enrollees.

3.3 Policies and Procedure Assistance: Holman shall be available to assist Employer in developing internal policies and procedures for referring enrollees to Holman for inpatient, day care, or outpatient Supplemental Mental Health and Substance Abuse Services.

3.4 Provision of MHSA Brochure: Holman shall provide a Supplemental Mental Health and Substance Abuse (MHSA) program brochure to Employer and shall consult with Employer and Employer's representatives about it.

3.5 Access to Holman: Holman shall make available to enrollees a dedicated telephone number of Holman (800-321-2843) for making appointments and obtaining information with respect to services provided by Holman pursuant to this Group Plan Contract. Enrollees can log into www.HolmanGroup.com, User Name: MiraCostaCollege & Password: MCC7123 to select a Holman contract provider. Once a Holman contracted provider has been selected from the Holman website, Holman must be called and informed of the provider's name by the Employer/enrollee.

3.6 Quality Control: Holman shall establish and maintain a quality control procedure, under the oversight of the Quality Management and Utilization Management Committees. This process will govern all private and group sessions provided by contracted providers, in order to assure delivery of effective health care services to enrollees.

3.7 Provider Ethics Requirement: Holman shall require all contracted providers and their authorized professional employees to abide by all ethical principles and standards of their respective professions.

3.8 Premiums and Benefits Increase/Decrease: Holman shall not increase the amount of the Premium to be paid by Employer, or otherwise increase the compensation to be paid to Holman by Employer for services provided pursuant to this Group Plan Contract except annually upon renewal or after a period of at least 30 days from and after the postage paid mailing to the Employer at the Employer most current address of record with Holman. Holman shall not decrease the amount of benefits to be provided pursuant to this Group Plan Contract except annually upon renewal as may be agreed upon by Holman and Employer or after a period of at least 30 days from and after the postage paid mailing to the Employer at the Employer's most current address of record with Holman.

3.9 Provider Insurance: Holman shall require that all providers have malpractice liability insurance coverage for one million dollars ($1,000,000.00) per each occurrence and one million dollars ($1,000,000.00) in the aggregate.

3.10 Holman Insurance: Holman will carry:

3.10.1 Comprehensive general liability insurance, $1,000,000 each occurrence (bodily injury and property damage) and 3,000,000 aggregate for all claims. Business personal property insurance on all Holman facilities up to the amount of $1,200,000.

3.10.2 Statutory Worker's Compensation insurance coverage for all Holman employees up to California Statutory limit of $1,000,000.

3.10.3 Fidelity Bond for crime in the amount of $1,000,000 in compliance with applicable Department of Managed Health Care regulations.

3.10.4 Primary Managed Care Errors & Omissions Coverage of $1,000,000 for each claim & $3,000,000 aggregate for all claims.

4.0 GENERAL PROVISIONS

4.1 Period of Coverage: Coverage of enrollees shall become effective on the date set forth on Exhibits A and B (see Period of Coverage span) provided Employer has paid the required Premium, and coverage shall end on the last day of month for which Premium was paid or when this Group Plan Contract is terminated.

4.2 Copayments/Deductibles: Enrollee and enrollee's eligible dependent(s) are responsible for the copayment amounts specified in the Benefits Schedule. The copayment amount may be a specific dollar amount or a percentage of the contracted provider's charge, depending on the service provided.

4.3 Service Specifics: Outpatient services shall be provided by Holman in either Holman's offices, providers' offices, or in an office provided by Employer at an Employer's location. Normally services shall be delivered within five business days of a request by an enrollee. Emergency services will be available on a 24-hour-per-day, 7-day-per-week basis. Inpatient and day care services shall be provided by Hospitals or Sub-Acute Care Facilities under contract with Holman. Day care, Behavioral Health Service, and Sub-Acute Care Facilities, may not be available in all geographical areas. Because of the specialized nature of the treatment programs at these facilities and their limited availability, enrollees may have to travel at their own expense to distant communities to obtain these services as covered benefits.

4.4 Confidentiality and Records: Holman will maintain the confidentiality of all enrollee records in accordance with the Health Information Portability and Accountability Act (HIPAA) and other applicable federal and state laws. Except to the extent that disclosure is authorized by the enrollee in writing or is otherwise mandated or permitted by law.

A STATEMENT DESCRIBING HOLMAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE

AND WILL BE FURNISHED TO THE EMPLOYER AND/OR ENROLLEE UPON REQUEST.

Providers are required to maintain records and provide such information Holman or to the Director as may be necessary for compliance by the plan with provisions of the Act and the rules thereunder; that such. Records will be retained by the provider for at least two years, and that such obligation is not terminated upon a termination of the agreement, whether by rescission or otherwise.

4.5 Choice of Providers: A Holman clinician or Care Access specialist will refer enrollees to contracted providers in their community. Enrollees can log into www.HolmanGroup.com, (User Name: MiraCosta College & Password: MCC7123) to select a Holman contracted provider. Once a Holman contracted provider has been selected from the Holman Website, Holman must be called and informed of the provider's name by the "Company Name" enrollee. If the enrollee uses a non-contracted provider, the enrollee may choose which non-contracted provider to use and is responsible for arranging for services to be rendered and for any charges incurred. Holman shall not reimburse enrollees who secure services from licensed non-contracted providers, except in emergency cases or as outlined in this Group Plan Contract. Section 1.5 defines contracted providers.

4.6 Concurrent Reviews: In order to determine continuing Medical Necessity for an enrollee's treatment, concurrent reviews of enrollee's treatment will occur on a regular basis. During each review, a Holman Health Care Advisor monitors the enrollee's course of treatment to dete1mine its effectiveness, the appropriate level of care, and continued Medical Necessity. The Holman Health Care Advisor must authorize all extended lengths of stay and transfers to different levels of care as well as any related additional services. Holman's Process and Criteria for determining Medical Necessity will be furnished to the enrollee upon request.

4.7 Enrollee Reimbursement Provisions: Holman has made arrangements with its contracted providers to ensure that all bills are submitted directly to Holman for payment. However, if an enrollee receives emergency behavioral health treatment from a non-contracted provider, the enrollee may receive a bill for such services. The enrollee must provide Holman with a copy of the bill or claim as soon as possible. Enrollees should mail claims to: Holman Professional Counseling Centers, PO Box 8011, Canoga Park, CA 91309.

4.8 Holman Provider Compensation Procedure: Holman provider hospitals, acute care, subacute care, and transitional care facilities, are all paid on a discounted fee-for-service or fixed charge per day. Holman does not use or pe1mit any type of financial bonuses or incentives in its contracts with providers.

4.9 Emergency Substance Related Treatment: Holman covers emergency Substance Related Treatment worldwide. When an enrollee has a Substance Related emergency, the enrollee or someone acting on the enrollee's behalf, must notify Holman within 24 hours of the

emergency admission, or as soon as reasonably possible. Holman must coordinate continuing or follow-up Substance Related Treatment Services to emergency treatment. Holman may elect to transfer the enrollee to a contracted provider, provided the transfer would not create an unreasonable risk to the enrollee's health as determined by Holman. Holman will not cover non-emergency Substance Related treatment provided by non-contracted providers and Hospitals unless otherwise stated in the Agreement.

4.10 Continuity of Care for New Enrollees Receiving Services for an Acute or Serious Chronic Substance Related Treatment: Holman will make every effort to facilitate the Continuity of Care for new enrollees who are in treatment for an acute or serious chronic Substance Related Disorder counseling at the time of enrollment. Financial arrangements with providers that are not Holman providers are negotiated on a case by case basis. We will ask that the providers agree to accept reimbursement and contractual requirements that apply to Holman providers, including payment terms. If the provider does not agree to accept said reimbursement and contractual requirements, we are no required to continue that provider's services. Review procedures will be provided to all eligible enrollees upon request. Enrollees may contact Holman directly at l-800-321-2843 for assistance with continuity of care issues. Continuity of Care for new enrollees will be provided in general accordance with applicable "Transition Assistance for New Members" section in their Combined Evidence of Coverage and Disclosure Form booklet.

4.11 Continuity of Care for EAP Services: If an enrollee is currently receiving EAP services through a previous health plan, the enrollee needs to contact Holman at 1 (800) 321-2843. If the enrollee's current provider is not a Holman network provider, Holman will arrange for an appropriate transition of the enrollee's care to a Holman network provider.

4.12 Continuity of Care for Enrollees Receiving Services with a Terminated Provider: At the request of an enrollee who is undergoing an acute or serious chronic condition at the time of a provider te1mination, Holman will provide for the continuation of covered services for a limited time with that terminated provider, as long as provider's termination was not for medical or criminal disciplinary action. Holman will furnish the enrollee with Behavioral Health Services from the te1minated provider for up to ninety (90) days or a longer period if necessary for a safe transfer to another Provider as determined by Holman in consultation with the te1minated provider, and consistent with good professional practice. All efforts will be made for enrollees utilizing their Supplemental Mental Health and Substance Abuse services to continue to have continuity of care without disruption of services. To request continued care from a te1minated provider, the enrollee must contact Holman Care Access Department at 1-800-321-2843.

4.13 Liability of Holman upon Provider Termination: Upon termination of a Provider Agreement by any contracted provider, Hospital or Sub-Acute Care Facility, Holman shall be liable for covered services rendered by such provider, Hospital, or Sub-Acute Care Facility to an enrollee who retains eligibility under the Group Plan Contract and who is under the care of such provider, Hospital, or Sub-Acute Care Facility at the time

of such termination until the services being rendered by such provider, Hospital, or Sub-Acute Care Facility are completed. Holman may make appropriate provisions for the assumption of such services by another provider, Hospital or Sub-Acute Care Facility.

4.13.1 Holman shall provide 30-day written notice to any enrollee whose provider terminates, breaches the contract, or is unable to perform within the limits of the law. Holman will also provide this notice if the provider's actions may materially or adversely affect the enrollee.

4.14 Coordination of Benefits: Pursuant to the provisions below, Holman will not be responsible for making payments for services when another plan is primarily responsible for making payment for such services:

4.14.1 A "Plan" is considered to be any group insurance coverage or other arrangement of coverage for individuals in a group that provides benefits or services on an insured or uninsured basis, and any governmental program providing benefits or services of a similar nature.

4.14.2 An "allowable expense" is any necessary, reasonable and customary mental health expense covered by Holman and covered in full or in part under any one of the plans involved.

4.14.3 With respect to coordinating benefits with other carriers, the "primary" Plan pays its benefits without regard to any other plans. The "secondary" plans adjust their benefits so that the total benefits available will not exceed the allowable expenses. No plan will pay more than it does without the coordinating provision.

4.14.4 A plan without a coordinating provision is always the primary plan. If all plans have such a provision (1) the plan covering the enrollee directly, rather than an enrollee's dependent, is primary and the others are secondary; (2) if a child is covered under both parents' plans, when two enrollees are under the same plan in a family, the enrollee whose bi1ihday falls first in a calendar year is the one who will be utilized; (3) if neither (1) nor (2) applies, the plan which has covered the enrollee the longest period of time is primary.

4.14.5 Employer shall provide Holman with any information it may have regarding other plans of its enrollees that may cover services provided by Holman. Holman may exchange benefit information with insurance companies, organizations and individuals, and has the right to recover any overpayment made from Employer if there is neglect by Employer in reporting coverage under another plan.

4.14.6 An enrollee may not be covered as a subscriber and as a dependent on a plan, and an enrollee's dependents may not be covered by more than one Plan. If an enrollee is a subscriber and is also a dependent of a subscriber, the enrollee will be insured solely as a subscriber and all copayments will be waived. In this case, the combined maximum contractual benefits to which an enrollee is entitled under

the terms of the master contract is not to exceed in the aggregate 100 percent of the charge for the covered expense or service. If an enrollee and spouse belong to different Holman plans, each of the children, stepchildren, and legally adopted children may be insured under one Holman plan only and all copayments will be waived.

4.15 Charges for Missed Appointments (Contracted Providers Only):

Supplemental Mental Health and Substance Abuse Services Outpatient Sessions- For missed sessions, an enrollee will be charged their copay or a sum of thirty-five dollars ($35.00) (whichever is greater), directly to the contracted provider for any appointment made with contracted provider that is not kept, except in the case where the contracted provider is notified at least twenty-four (24) hours in advance of the appointment that it will not be kept or the failure to keep the appointment was due to circumstances beyond the enrollee's reasonable control.

4.16 Liability of Enrollee for Payment for Pre-Authorized Service: Every contract between Holman and its contracting providers will contain a provision stating that enrollees shall not be responsible for payment to any contracted provider in the event that Holman should fail to pay the provider for services rendered, unless such services are determined to not be covered under this Agreement. Authorized treatment by a provider shall not be rescinded or modified after the provider renders the service in good faith pursuant to the authorization.

4.17 Second Medical Opinions: An enrollee or participating provider, who is treating an enrollee, may request a second medical opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

- Reasonableness or necessity of recommended treatment is questioned.
- Diagnosis or treatment plan is questioned.
- Clinical indications are not clear or are complex and confusing.
- Treatment plan in progress is not improving the condition of the enrollee within an appropriate period of time given the diagnosis and plan of care.

Holman's decision to grant or deny the request for a second medical opinion will be delivered to the individual who requested the second medical opinion. If the enrollee faces an imminent and serious threat to his or her mental health, the second opinion shall be rendered within (72) hours after the receipt of the request. If the request for a second opinion is approved, the enrollee will be responsible for all applicable copayments. If the request for a second opinion is denied, the enrollee will be notified in writing of the reasons for the denial and shall be informed of the right to file a grievance with the Plan. The request for a second medical opinion can be made by calling Holman at 1-800-321-

2843, or by writing to: Holman Professional Counseling Centers, Care Management Department, PO Box 8011, Canoga Park, CA 91309.

4.18 Independent Medical Review Process:

4.18.1 The California Department of Managed Health Care provides an Independent Medical Review process for coverage decisions that have been denied, modified, or delayed by a decision of Holman due to a finding that the service is not Medically Necessary.

4.18.2 Holman shall provide enrollees whose coverage request has been denied, modified, or delayed due to a finding that such treatment is not Medically Necessary with the oppo1itmity to seek an independent review. An enrollee may apply to the Department within six months of Holman's denial, modification, or delay of a coverage decision, for an Independent Medical Review when all of the following conditions are met:

a. Enrollee's provider has recommended a health care service as Medically Necessary, or enrollee has received urgent care or emergency services that a provider determined was medically necessary; or enrollee, in the absence of a provider recommendation or the receipt of urgent or emergency care services by a provider, has been seen by contracted provider for the diagnosis or treatment of the medical condition for which the enrollee seeks Independent Medical Review.

b. The disputed health care service has been denied, modified, or delayed by Holman based in whole or in pa1i on a decision that the health care service is not Medically Necessary.

c. The enrollee has filed a grievance with Holman and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days, or three (3) days in the case of an expedited review case.

4.18.3 The enrollee has the right to file information in support of the request for review. The Independent Medical Review panel shall provide the Department of Managed Health (DMHC) Care Director, Holman, the enrollee, and the enrollee's provider with an analyses and dete1mination of the case. The DMHC Director shall immediately adopt the determination of the independent medical review organization, and shall promptly issue a written decision to the parties that shall be binding on Holman.

4.18.4 Upon receiving the decision of the DMHC Director that a disputed health care services is medically necessary, Holman shall immediately contact the enrollee and offer to promptly implement the decision.

4.18.5 An enrollee's decision not to participate in the Independent Medical Review Process may cause the enrollee to forfeit any statutory right to pursue legal action against Holman regarding the disputed health care service.

4.18.6 Additional information on the Independent Medical Review Process may be obtained by contacting Holman by phone at 1-800-321-2843 or in writing at Holman Professional Counseling Centers, PO Box 8011, Canoga Park, CA 91309.

4.19 Experimental/Investigational Therapies- External, Independent Review Process: Holman will provide an external, independent review process for treatment decisions regarding *experimental or investigational therapies for individual enrollees who meet all of the following criteria*:

4.19.1 Enrollee has a life-threatening or Substance Related condition;

4.19.2 Enrollee's physician certifies that the enrollee has a life-threatening Substance Related or seriously debilitating Substance Related condition for which standard therapies would not be medically appropriate for the enrollee or for which there is no more beneficial standard therapy covered by the plan than the therapy proposed in the next section 4.19.3;

4.19.3 Either 1) the enrollee's contracted provider has recommended a drug, device, procedure, or other therapy that the provider certifies in writing is likely to be more beneficial to the enrollee than any available standard therapies, or 2) the enrollee, or the enrollee's contracted provider, has requested a therapy that, based on two documents from the medical and scientific evidence, is likely to be more beneficial for the enrollee than any available standard therapy. The provider certification pursuant to this section shall include a statement of the evidence relied upon by the provider in certifying his or her recommendation;

4.19.4 Enrollee has been denied coverage by Holman for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph 4.19.3 above;

4.19.5 The specific drug, device, procedure, or other therapy recommended pursuant to paragraph 4.19.3 above would be a covered service, except for Holman's determination that the therapy is experimental or investigational.

For those enrollees who meet the above listed criteria, Holman will offer the opportunity to have the requested therapy reviewed under the external, independent review process. Holman will notify the enrollee in writing of this opportunity to request such review within five (5) business days of the decision to deny coverage. The enrollee has the right to file information in suppo1t of the request for independent review.

The external, independent review, panel, consisting of at least two experts, shall render a decision within thirty (30) days of receipt of the review request, unless a shorter time period is warranted by the enrollee's condition. If a majority of the expert panel

recommends the experimental or investigational treatment, the decision shall be binding on Holman. If the panel is evenly divided, the treatment shall be provided by Holman. If less than half of the panel recommends against the experimental or investigational treatment, then Holman is not required to provide the treatment.

4.20 Renewal Provisions: This Group Plan Contract is for an initial term of 18 months. The Group Plan Contract may be automatically renewed annually on 1/1 at the agreed upon rates, unless terminated pursuant to Section 4.21. The total term of this agreement shall not exceed five years from the effective date. Employer will notify enrollees of any change to the Group Plan thirty (30) days prior to the effective date of coverage.

4.21 Cancellations, and Nonrenewal: Cancellation, termination or nonrenewal of this Group Plan Contract may only be effected in accordance with the following provisions:

4.21.1 This Group Plan Contract may be canceled, terminated or non-renewed by Holman for the following reasons:

a. Failure to pay. For nonpayment of the required premiums owed to Holman if the Employer has been duly notified and billed for the charge and at least a 30-day grace period has elapsed since the date of the receipt of the last premium payment. Coverage will continue during the grace period; however, the Employer will be still responsible to pay unpaid premiums and the Enrollee will be responsible for any copayments, coinsurance or deductible amounts required under the group plan contract.

b. Fraud. For fraud or misrepresentation by Employer with respect to coverage of individuals, the individuals, or their representatives.

c. In all instances of cancellation in (a) and (b) aforementioned, written notice will be given thirty (30) days prior to date of cancellation and cancellation will not be retroactive. Enrollment will be cancelled as of the last day of the 30-day grace period following the receipt of the last payment.

4.21.2 Holman may terminate, cancel or decline to renew this Agreement when required to effectuate the purposes of the Knox-Keene Health Care Service Plan Act, with the consent of the Director of the Department of Managed Health Care.

4.21.3 All benefits under this Contract shall cease as of the date of cancellation, te1mination, or nonrenewal with Holman and Employer being released from all further obligations.

4.21.4 In the event of cancellation by Holman-(except in the case of fraud or deception in the use of services or facilities of Holman or knowingly permitting such fraud or deception by another) or by Employer, Holman shall, within thirty (30) days, return to Employer the prorated portion, if any, of the money paid to Holman

which co1Tesponds to any unexpired period of which payment has been received, less any amounts due Holman.

4.21.5 Acceptance by Holman of the proper prepaid or periodic payment, after te1mination of this Group Plan Contract and without requiring new application, shall reinstate the Contract as though it had never terminated or been canceled unless Holman shall, within five (5) business days of receipt of such payment, either refund the payment so made or issue to the other party a new contract accompanied by written notice stating clearly those respects in which the new contract differs from the terminated contract in benefits, coverage, or otherwise.

4.21.6 Section 1374.72 of the Health and Safety Code requires health care plans to provide coverage for the diagnosis and medically necessary treatment and management of mental health services (as defined) in a manner that matches Employer medical plan benefits. In order to ensure that this matching is current and accurate, Employer must notify Holman of any benefit changes in their full service health plan within 90 days of the effective date of such changes.

4.21.7 In the case of this group plan contract, violation of a material contract provision relating to Employer contribution or group participation rates by the contract holder or Employer.

4.22 Individual Continuation of Services: Federal COBRA Provisions:

A subscriber or eligible dependents may choose to continue coverage under the agreement if their coverage would othe1wise end due to a Qualifying Event, as listed below.

4.22.1 The Federal Consolidated Omnibus Reconciliation Act of 1985 provides for the continuation of health insurance coverage for eligible enrollees and their dependents, of Employers/Trusts with 20 and over eligible Enrollees, for a defined period of time after certain qualifying events occurs. Ordinarily, an enrollee's benefits will cease when Employer/Trust's group coverage terminates or under any other circumstance listed in "Termination of Benefits." However, in the case of certain qualifying events, a qualified enrollee and enrollee's Eligible Dependents may be able to continue group plan coverage under federal COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) provisions for a limited time, if enrollee agrees to pay the Premium for such coverage. A qualified enrollee is an enrollee, who on the day before a qualifying event, is an enrollee in a group benefit plan offered by a health care service plan, and who has a qualifying event. A qualifying event is limited to the following: death of covered enrollee; termination of employment for reasons other than gross misconduct; divorce or legal separation of the covered enrollee from the covered enrollee's spouse; or loss of dependent status by a dependent enrolled in the Group Plan.

4.22.2 The qualified enrollee shall, upon election, be able to continue his or her coverage under the Employer Group Plan Contract, subject to the Group Plan's terms and conditions, for a limited amount of time. The enrollee must elect COBRA coverage by notifying the enrollee's Employer/Trust in writing within sixty (60) days of the date of the qualifying event. The written request must be delivered by first class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the Employer/Trust within the sixty (60) day period following the later of 1) the date that the enrollee's coverage under the Group Plan Contract terminated or will terminate by reason of a qualifying event, or 2) the date the enrollee was sent notice of the ability to continue coverage under the Group Plan Contract.

4.22.3 The failure to notify the Employer/Trust within the required sixty (60) days will disqualify the qualified beneficiary from receiving continuation coverage under COBRA provisions. An enrollee electing continuation shall pay to the Employer/trust in accordance with the terms and conditions of the group plan contract, the amount of the required Premium payment. The enrollee's first Premium payment required to establish Premium payment shall be delivered by first-class mail, ce1tified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the Employer/Trust within forty-five (45) days of the date the qualified beneficiary provided written notice to Employer/Trust, of the election to continue coverage, in order for coverage to be continued under COBRA provisions.

4.22.4 The first Premium payment must equal an amount sufficient to pay any required Premiums and all Premiums due, and failure to submit the correct Premium amount within the forty-five (45) day period will disqualify the enrollee from receiving continuation coverage pursuant to COBRA provisions. Enrollees whose continuation coverage te1minates under a prior Group Plan may continue their coverage for the balance of the period that the enrollee would have remained covered under the prior Group Plan. Enrollees electing to continue coverage must notify Employer/Trust in writing and pay to the Employer/Trust the required Premium payments. The continuations coverage will terminate if the enrollee fails to comply with the requirements pertaining to enrollment in, and payment of Premiums to, the new Group Plan Contract within thirty (30) days of receiving notice of the termination of the prior group plan contract.

4.22.5 A qualified enrollee can request Cal-Cobra at the conclusion of their Federal Cobra benefits explained below.

Cal-Cobra Provisions (applicable only to California enrollees):

The California Continuation Benefits Replacement Act (Cal-COBRA) provides that continued access to health insurance coverage is provided to Enrollees, and their dependents, of Employers/Trusts with 2 to 19 eligible enrollees who are not

currently offered continuation coverage under the federal COBRA, and those Eligible enrollees who have exhausted their Federal COBRA benefits. For a California qualified enrollee whose Cal-COBRA coverage begins on or after January 1, 2003, and who has exhausted continuation coverage under COBRA, the enrollee may extend their Cal-COBRA coverage for up to 36 months after the date the qualified enrollee's benefits under a group plan health contract would otherwise have ended because of a qualifying event if the enrollee agrees to pay the Premium for such coverage. A qualified enrollee is an enrollee, who on the day before a qualifying event is an enrollee in a group benefit plan offered by a health care service plan, and who has a qualifying event. A Cal-COBRA qualifying event is limited to the following: death of covered enrollee, termination of employment for reasons other than gross misconduct; divorce or legal separation of the covered enrollee from the covered enrollee's spouse, or loss of dependent status by a dependent enrolled in the group plan.

The qualified enrollee must notify their Employer/Trust within 60 days of the date of the qualifying event. Failure to make such notification within the required 60 days will disqualify the enrollee from receiving continuation coverage. A qualified enrollee who wishes to continue coverage under the group benefit plan must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the Employer/Trust -within the 60-day period following the later of (1) the date that the enrollee's coverage under the group benefit plan te11ninated or will te1minate by reason of a qualifying event, or (2) the date the enrollee was sent notice of the ability to continue coverage under the group benefit plan.

A qualified beneficiary electing continuation shall pay to their Employer/Trust the required Premium on or before the due date of each payment but not more frequently than on a monthly basis. The Premium will not be more than 110 percent of the applicable rate charged for a covered Enrollee 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 their Employer/Trust 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 qualified enrollee's first Premium payment required to establish Premium payment shall be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the Employer/Trust within 45 days of the date the qualified enrollee provided written notice to the Employer/Trust of the election to continue coverage. The first Premium payment must equal an amount sufficient to pay any

required Premiums and all Premiums due, and failure to submit the co1Tect Premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage. In the event the qualified enrollee does not receive information from Employer/Trust, i.e. Premium amount and due date, the qualified enrollee should contact Holman using the contact information provided below.

Individuals not eligible for Cal-COBRA are those who: are entitled to Medicare benefits; have other hospital, medical, or surgical coverage; are eligible for federal COBRA; are eligible for coverage under Chapter 6A of the Public Health Service

Act; fail to meet the specified time limits for electing coverage; and, fail to submit the correct premium amount required.

Enrollees whose continuation coverage terminates wider a prior group plan may continue their coverage for the balance of the period that the enrollee would have remained covered under the prior group plan. Enrollees electing to continue coverage must notify Employer/Trust in writing and pay to the Employer/trust the required Premium payments. The continuations coverage will te1minate if the enrollee fails to comply with the requirements pertaining to enrollment in, and payment of Premiums to, the new group plan contract within thirty (30) days of receiving notice of the termination of the prior group plan contract.

For more information on how to extend their Cal-COBRA coverage, the enrollee should contact Lisa Solomon by phone at 1-800-321-2843, or in writing at Holman Professional Counseling Centers, PO Box 8011, Canoga Park, CA 91309.

4.23 Language Interpretation: Holman retains sole, full and final discretionary authority to construe and interpret the language of all provisions in this contract, in order to clarify its initial intention when and if there are questions of fact and law arising regarding any Holman provisions.

5.0 EXCLUSIONS:

Unless otherwise indicated, all Exclusions apply to the Supplemental Mental Health and Substance Abuse Services Program.

5.1 Supplemental Mental Health and Substance Abuse Services provided by non-contracted providers except for those that qualify as emergency substance related treatment hospital admissions or otherwise authorized by Holman are not a covered benefit.

5.2 Employee Assistance Program (EAP) Services are **not a covered benefit.**

5.3 For those enrollees utilizing EAP services requiring emergency room services, these services will be provided by the patient's primary behavioral health plan (Anthem Blue

Cross). For those enrollees utilizing Supplemental Mental Health and Substance Abuse Services requiting emergency room services please refer to sections B and D in Exhibit A (page 30). Not applicable.

5.4 Treatment sessions provided by text messaging or SMS are not a covered benefit unless in an emergency and are provided through a state or nationally recognized crisis service.

5.5 Mental Health or Substance Abuse Court ordered inpatient and outpatient treatment is covered only when Medically Necessary. Reporting to the court and interacting with the court are not covered services.

5.6 For court ordered therapy, please refer to your Kasier medical plan behavioral health coverage for services for services that may be covered there.

5.7 Academic or educational testing; Services to remedy an academic or educational problem.

5.8 Psychotherapy used as professional training and not for the treatment of a medical or mental condition is not a covered benefit.

5.9 Use of sexual surrogate, sexual treatment of sexual offenders or perpetrators of sexual violence are not a covered benefit. Reporting to the court and interacting with the court are not covered services under this Agreement.

5.10 Pastoral or spiritual counseling by an unlicensed non-contracted provider will not be covered under this benefit plan.

5.11 All non-prescription and prescription drugs prescribed in connection with an enrollee's treatment are not a covered benefit.

5.12 Therapy specifically for the sole purpose of consciousness raising.

5.13 Surgery, acupuncture or physical therapy are not covered benefits.

5.14 Neurological services and tests, including but not limited to: EEGs, PET scans, beam scans, MRIs, skull X-rays, and lumbar punctures are not covered benefits.

5.15 Work, career, employment, or professional related evaluations, treatments, or counseling for non-medical purposes are not covered benefits.

5.16 Mental Health and Substance Related Acute care hospital benefit is limited to emergency services only. Emergency services include all hospital treatment and hospital ancillary services necessary to stabilize the emergent condition. Prior authorization is not required for emergencies.

5.17 Mental Health and Substance Related emergency non-contracted provider hospital admissions and outpatient psychiatric admissions set forth in the Schedule of Benefits (Exhibits A and B). Holman uses RBRVS (professional) and DRGs (hospital), as well as billing data collected by Holman to calculate reimbursement for the maximum allowable charge. Efforts are directed on ensuring that members are not balanced billed (except for co-pays) for emergency and/or post stabilization care.

5.18 Bio-feedback & Neuro-feedback must be specifically preauthorized.

5.19 Holman is the decider of Medical Necessity subject to the DMHC' s Independent Medical Review Process.

5.20 Mental Health and Substance Abuse Treatments which are not medically necessary benefits in Exhibit B (pages 33-34) may be provided by the primary behavioral health plan (Kaiser) and may not be a covered benefit from Holman. If an enrollee has any questions or concerns they may call Holman at 1-800-321-2843.

6.0 ENROLLEE GRIEVANCE PROCESS

6.1 Enrollee Grievance Process: Grievances will be directed to the Compliance Specialist. Enrollee's shall have up to 180 calendar days following any incident or action that is the subject of the enrollee's dissatisfaction to file a grievance with Holman. The Compliance Specialist will work together with the enrollee to resolve the issue if possible. If no solution is reached, the Compliance Specialist will refer the matter to the Grievance Committee. The Holman Grievance Committee will review the grievance and within thirty (30) days from Holman's receipt of the grievance, Holman will send a written notice of the resolution. If the grievance is denied, the notice will explain how the enrollee may appeal the decision of the Grievance Committee. Holman shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance.

6.2 Arbitration: If the enrollee remains dissatisfied with the decision, the enrollee may submit a request to Holman to submit the appeal to binding Arbitration before the American Arbitration Employer. Pursuant to California law a single neutral arbitrator who shall be chosen by the parties and who shall have no jurisdiction to award more than $200,000 must decide any claim of up to $200,000. However, after a request for arbitration has been submitted, Holman and the enrollee may agree in writing to waive the requirement to use a single arbitrator and instead use a tripartite arbitration panel that includes the two pa1iy- appointed arbitrators or a panel of three neutral arbitrators or another multiple arbitrator system mutually agreeable to the parties. The enrollee shall have three (3) business days to rescind the waiver agreement unless the agreement has also been signed by the enrollee's attorney, in which case the waiver cannot be rescinded. In cases of extreme hardship, Holman may assume all or part of the enrollee' s share of the fees and expenses of the neutral arbitrator provided the enrollee has submitted a

hardship application with the American Arbitration Employer. The American Arbitration Employer shall determine the approval or denial of a hardship application. A hardship application may be obtained by contacting the American Arbitration Employer in Los Angeles at 213-383-6516, in Orange County at 714-474-5090, in San Diego at 619-239-3051 and in San Francisco at 415-981-3901.

6.2.1 If the enrollee does not request arbitration within six months from the date of the Appeal Resolution Notice, the decision of the Appeal Committee shall be final and binding. However, if the enrollee has legitimate health or other reasons which would prevent them from electing binding arbitration in a timely manner, the enrollee will have as long as necessary to accommodate his or her special needs in order to elect binding arbitration. Further, if the enrollee seeks review by the DMHC, the enrollee will have an additional ninety (90) days from the date of the final resolution of the matter by the DMHC to elect binding arbitration. Upon submission of a dispute to the American Arbitration Employer, both the enrollee and Holman agree to be bound by the rules of procedure and decision of the American Arbitration Employer. Full discovery shall be permitted in preparation for arbitration pursuant to California Code of Civil Procedure, Section 1285.05

6.3 Expedited Grievance/Appeal Review: For cases involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, Holman provides expedited review. When Holman has notice of a case requiring expedited review, Holman shall immediately inform the enrollee in writing of their right to notify the DMHC of the request. For these cases, Holman will provide the enrollee and the Department with a written statement on the disposition or pending status of the request no later than three (3) days from receipt.

6.4 Treatment Denials: If a provider or enrollee notifies Holman of a dissatisfaction regarding a treatment authorization denial, it will be directed to the assigned staff. Holman will work together with the provider and/or enrollee to resolve the complaint. Within thirty (30) days from Holman's receipt of the complaint, Holman will send the provider and/or enrollee a written notice of the resolution. If the provider or enrollee's complaint is denied, the notice will explain how the provider or enrollee may appeal the decision.

6.5 Treatment Denial Appeals: If the provider/enrollee is dissatisfied with Holman's resolution of the treatment denial, the provider/enrollee may file an Appeal by notifying Holman of his/her dissatisfaction. The Appeal will be determined by a Holman staff psychiatrist for inpatient care or by the Holman doctoral level staff practitioner for outpatient care. Written notice of the Appeal Committee's decision will be sent to the provider/enrollee within thirty (30) days of receipt of the appeal notice.

6.5.1 Expedited reviews of treatment denials are available to providers and/or enrollees. In these cases, Holman will provide verbal resolution within eight (8) business

hours of Holman's receipt of necessary information to make an informed decision and in writing within two (2) days of receipt.

6.6 California Department of Managed Health Care: The California Depa1tment of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Holman Professional Counseling Centers, you should first telephone Holman Professional Counseling Centers at (l-800-321-2843) and use Holman Professional Counseling Centers' grievance process before contacting the Depa1tment. 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 Holman Professional Counseling Centers, or a grievance that has remained unresolved for more than thirty (30) days, you may call the Depa1iment 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 impa1iial review of medical decisions made by Holman Professional Counseling Centers 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 website http://www.l,mohelp.ca.gov has complaint forms, IMR application forms and instructions online. Holman also has these forms and will furnish them as appropriate and required.

7.0 GENERAL

7.1 Holman's Medical Necessity Philosophy: Includes authorizing the most intensive treatment in the least restrictive setting because life's problems MUST be solved while engaged in life; living at home, on the job and with family/friends. At the same time, as the enrollee starts to put into practice the coping mechanisms and life skill tools that are learned or re-awakened in therapy, when possible, we want the enrollee to start to stand on their own without developing a dependency on a therapist. This standing on your own can result in scheduling sessions every other week to every three/four weeks. Once ending a course of treatment and implementing the NEW coping tools for some time and as medical needs dictate, enrollees are always encouraged to call again.

7.2 Holman's Public Policy Committee: Holman operates a Public Policy Committee that is mandated to maintain professional standards. It functions as an open form to provide enrollees with an opportunity to discuss prevailing societal issues, difficulties with current policies, and additional available services. The purpose of the Public Policy Committee is to ensure the comfo1t, dignity, and convenience of persons relying upon Holman for Behavioral Health Services. In order to assure enrollee participation in Holman policy, the Public Policy Committee shall consist of the following members: Holman Executive Vice President, Director of Corporate Account Management, Account Management staff and a minimum of three current enrollees. The Executive Vice President selects the enrollee members of the Public Policy Committee. Any enrollee

interested in the Public Policy Committee may direct his or her request in writing to: Holman Professional Counseling Centers, PO Box 8011, Canoga Park, CA 91309.

7.3 Language Assistance Program ("LAP"): The DMHC of California has added Section 1300.67.04 (Language Assistance Programs) to Title 28 California Code of Regulations. This new regulation requires health care service Plans to implement new policies, procedures and quality improvement efforts in regards to assisting those who are Limited English Proficient ("LEP"). The DMHC regulations require California Health Plans to set up a system where services, materials, and information are provided to members in a language that they speak and understand.

In accordance with the DMHC regulations, Plan has identified its threshold language(s) which comprise five (5) percent of its enrollee Population. All vital documents as identified by the DMHC will be translated into the threshold language. All non-vital documents will contain a notice at the bottom of said document (in the threshold language) info1ming the member how to request a translation of the document.

The Plan has established a free Language Assistance Program and made the following resources available for LEP individuals: Translations (in the threshold languages), Interpreters, and Bilingual staff/providers. These resources are available for all persons who request these services at any of our points of contact.

7.4 Antifraud Policy and Procedures: Holman makes every effort to detect, investigate, and prosecute any incidents of fraud at any level within its Behavioral Health Service. Holman contracts with a special investigator trained in fraud investigation to assist us in investigating fraud. In the event that Holman detects any fraudulent activity on the part of a provider, the provider's contract with Holman will be terminated. If Holman detects any fraudulent activity on the part of an enrollee or Employer, Holman will deny enrollee any additional benefits under enrollee's Group Plan and may terminate Employer or the enrollee. Additionally, Holman will prosecute fraud to the fullest extent of the law. We also cooperate with all government agencies in a combined effort to prevent and prosecute fraud on the part of both providers and enrollees.

7.5 Enrollees Held Harmless: As required by California law, every contract between Holman and a provider shall provide that the provider accepts the payment rate under the Holman Agreement as payment in full. The provider may not, under any circumstances bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the enrollee for services provided. The enrollee is held harmless and may not be balance billed. Collection from the enrollee of any copayments or deductibles in accordance with the te1ms of the benefit plan, or charges for services determined to not be covered under the plan, may be excluded from the hold harmless clause.

7.6 Approval of Materials: All materials published or distributed by Employer concerning this Group Plan Contract shall be approved by Holman prior to use.

7.7 Professionalism: Both parties to this Group Plan Contract agree to permit and encourage the professional relationship between providers and enrollees to be maintained without interference and in a manner that would enhance the confidentiality of services.

7.8 Notices: All notices provided hereunder shall be deemed as having been properly made upon depositing the same in the United States mail, postage prepaid, and addressing such notices to Holman at its administrative office, or to Employer at the address appearing last on the books of Holman.

7.9 Entire Contract: This Group Plan Contract contains all of the provisions of the agreement between the parties hereto, and no promise or agreement not contained herein shall be binding on the patties unless the same is mutually agreed upon in writing, signed by the parties hereto and attached to this Group Plan Contract. Only an officer or director of Holman has the power to change, modify, or waive the provisions of this Group Plan Contract, and then only in writing. Consent of enrollees is not required to effect any such change.

7.10 Assignment: Neither this Group Plan Contract nor any rights, obligations or duties under this Group Plan Contract may be assigned without the consent of contracting parties, provided however, that Holman may assign its rights, obligations or duties under this Contract to any corporate affiliate or other entity which may purchase substantially all assets of Holman or is the surviving entity in a merger with Holman.

7.11 Severability: If any provision of this Group Plan Contract is declared invalid or unenforceable by any arbitrator, court or other competent authority, the remaining provisions hereof shall remain in full force and effect.

7.12 Waiver: A failure of either party to exercise any right provided for herein shall not be deemed a waiver of any right hereunder. No party will be deemed to have waived any rights hereunder unless the waiver is made in writing and is signed by the waiving party's duly authorized representative. No waiver of a patty's right under this Agreement shall be deemed to have been effective if and to the extent waiver of such right is prohibited under applicable law.

7.13 Applicable Law: This Group Plan Contract shall be governed by and construed under the laws of the State of California.

7.14 Amendment: Except as otherwise specifically provided in this Agreement, this Agreement may be amended only by mutual written consent of the parties.

7.15 Effective Date: See Signature Page.

7.16 Employer/Holman Arbitration: Any controversy or claim arising out of or relating to this contract, including any claims for trot liability, bad faith liability, breach of contract, punitive damages or any other claim, but excluding medical malpractice claims by enrollees, shall be submitted to binding arbitration before the American Arbitration Employer. Arbitration must be initiated within six months after the alleged controversy or claim occurred by submitting a written demand to the other party. The failure to initiate arbitration within that period constitutes an absolute bar to the institution of any proceedings.

7.16. 1 The arbitration shall be conducted in the state of California. The complaining party serving a written demand for arbitration upon the other party initiates these arbitration proceedings. The written demand shall contain a detailed statement setting forth the nature of the dispute, the amount of damages involved, if any, and the remedy sought. Within ten (10) business days of that demand, Holman and Employer will appoint a mutually agreed upon arbitrator. A single neutral arbitrator who is licensed to practice law shall conduct the arbitration. If the pa1ties are unable to agree upon an arbitrator, the arbitrator shall be selected in the manner provided for by the American Arbitration Employer. Unless otherwise approved by the parties, any arbitrator appointed under this Contract shall have at least ten (10) years demonstrable experience in health care and managed care issues.

7.16.2 Each party shall have the right to take the deposition of up to five (5) individuals and any expert witness designated by the other party. At least thirty (30) days before the arbitration, the parties must exchange lists of witnesses, including any expe1ts (one of each for Holman and Employer) and copies of all exhibits to be used at the arbitration. No witness may be called, or exhibit introduced, at the hearing if not included on that list, except as pe1mitted by the arbitrator, upon a showing of good cause. A stenographic record shall be made of the proceedings, the cost of which shall be home equally by both pa1ties. The arbitrators shall dete1mine the rights and obligations of the parties according to the substantive laws of the state of California.

7.16.3 Any counterclaim, cross-claim, or third-party claim for indemnity or contribution between provider and Holman in any enrollee's action against Employer or Holman is expressly excluded from this arbitration clause, unless enrollee's entire action is judicially required to be submitted to arbitration.

7.16.4 Judgment upon the award rendered by the arbitrator may be entered in any court having competent jurisdiction. The decision of the arbitrator shall be final and binding. The arbitrator shall have no authority to make material errors of law or to award punitive damages to or to add to, modify, or refuse to enforce any agreements between the parties. The arbitrator shall make findings of fact and conclusions of law and shall have no authority to make any awaited that could not have been made by a court of law. The prevailing party, or substantially

prevailing party's costs or arbitration are to be borne by the other party, including reasonable attorney's fees.

7.16.5 By entering into this Contract, Employer and Holman waive their legal rights to have any dispute decided in a court of law before a judge or jury and instead accept the use of arbitration for resolving disputes arising from this Group Plan Contract.

The Plan is subject to the requirements of Chapter 2.2 of Division 2 of the Code and of Chapter 1 of Title 28 of the California Code of Regulations and any provision required to be in the contact by either of the above shall bind the Plan whether or not provided in the contract.

IN WITNESS WHEREOF, the parties hereto have entered into this Contract on July 1, 2023.

MiraCosta College
("Employer")

By: _____
Signature

_____
Name

_____
Title

_____
Date

HOLMAN PROFESSIONAL COUNSELING CENTERS ("HPCC")
A California Corporation

By: _____
Signature

Elizabeth Holman, M.B.A
Name

President
Title

_____
Date

EXHIBIT A
BENEFIT SCHEDULE

MiraCosta College

Supplemental Mental Health & Substance Abuse Plan (MHSA)

Effective 7/1/2023

Benefit Description	Holman Supplemental Mental Health & Substance Abuse Plan (Employees & Dependents on Kaiser Only)	
	In-Network You Pay	**Out-of-Network You Pay**
Annual Out-of-Pocket Limit	No Charge	
Office Visit Copayment	$20 Individual $10 Group	No benefit
	No Limit	
Hospital Inpatient Services and Alternate Care (Intensive Outpatient, Partial Hospital, Day Treatment & Residential)	No Charge	No Charge Emergency Only
Inpatient Hospital Maximum Day Limit	Authorization Required; No limit on number of days	
Ambulance charges (with a Substance Abuse diagnosis only)	No Charge	No Charge Emergency Only
Emergency Room (with a Substance Abuse diagnosis only)	No Charge	No Charge Emergency Only
Laboratory (with a Substance Abuse diagnosis only)	No Charge	No Charge Emergency Only

1. All treatment is subject to medical necessity and supplemental to the medical benefit.
2. Holman uses Medicare rates to calculate reimbursement for Non-contracted providers and facilities. Medicare rates and DRGs are government approved reimbursement calculations for the reasonable and customary value of healthcare services rendered. They are based upon statistically credible information that is updated annually and takes into consideration:
   a. The provider's training, qualifications and length of time in practice
   b. The nature of services provided
   c. The fees usually charged by the provider
   d. Prevailing providers rates charged in general geographic areas in which services were rendered

e. Other aspects of the economics of the medical provider's proactive that are relevant and any unusualcircumstances

3. Authorization and concurrent review is required for in and out of network.
4. Holman must be notified within 48 hours of admission for Emergency hospitalization.
5. Employees only are covered for the Supplemental Substance Abuse Plan benefit.
6. Employees have dual coverage for Substance Abuse Plan benefits through their medical plan and mental health benefits are covered through their medical plan as well. All employees that are eligible for the SA Plan Benefit that are made management referrals for Substance Abuse issues should go through Holman's MHSA plan.
7. Plan effective 7/1/2023 and renews annually.

Exhibit B

Supplemental Mental Health and Substance Abuse Services Evidence of Coverage (Disclosure Statement)

Benefit Schedule:
See Exhibit A for full benefit schedule.
Outpatient, Intensive Outpatient, Day Treatment, Partial Hospital, Residential and Inpatient levels of care are covered as Medically Necessary care.

To utilize benefits simply call **1-800-321-2843** for an appointment.

Notice to Plan Participants:
Federal law requires all employer benefit plan administrators to furnish each plan participant and each beneficiary receiving benefits under the plan, a copy of a summary plan description. **This summary plan description constitutes only a brief overview of the provisions of the Group Plan Contract that has been entered into between your Company and Holman Professional Counseling Centers, ("HPCC").** The Group Plan Contract must be consulted to determine the exact provisions of the Group Plan Contract. Your Company or HPCC will present a copy of the Group Plan Contract to you upon request.

Plan Name and Type of Administration: Employee Assistance Program (EAP) (not a covered benefit) and SA Plan

Plan Administrator:

MiraCosta College

1 Barnard Drive

Oceanside, CA 92056

Agent for Service of Legal Process:
Same as plan administrator

Behavioral Health Benefit Provider Company:
Holman Professional Counseling Centers is a California corporation, which provides Employee Assistance Program health services **(not a covered benefit)** to the plan participants of your Company's Flexible Compensation Plan. HPCC may be contacted at the following address and telephone number:

Holman Professional Counseling Centers
P.O. Box 8011, Canoga Park, CA 91309
(800)321-2843

Period of Coverage:
The Plan year is July 1st through December 31st.

Charges for Missed Appointments (Contracted Providers Only):
Employee Assistance Program Sessions- An enrollee will forfeit one session for failure to attend any session except in the case where the contracted provider is notified at least twenty- four (24) hours in advance of the appointment or the failure to keep the appointment was due to circumstances beyond the enrollee's reasonable control. **(EAP is not a covered benefit)**

Eligibility Requirements: Includes Eligible Employee's lawful spouse, domestic partner (as defined in Section 297 of the Family Code), and dependent children to age 26. Children include stepchildren, adopted children, and foster children, provided such children are dependent upon the employee for support and maintenance. Coverage for each minor child placed for adoption immediately begins from and after 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 spouse the right to control health care for the adoptive child. Attainment of the limiting age of 26 by dependent children, shall not operate to terminate the coverage of a child while the child is and continues to be incapable of self-sustaining employment by reason of physical or mental condition (certified by a doctor in writing) and the child is chiefly dependent upon an Eligible Employee for support and maintenance.

Renewal Provisions. The Group Plan Contract between your Employer and HPCC is for a term of two years unless otherwise indicated. Unless terminated in one of the methods included in "Termination of Benefits," the Group Plan Contract will be renewed annually at such rates and upon such terms as may be agreed upon by the HPCC and your employer at the time of renewal. The Employer will notify enrollees of any change to the Group Health Plan thirty (30) days prior to the effective date of change.

Termination of Benefits. If your Employer fails to pay HPCC the appropriate premiums for you and/or your dependents, HPCC may terminate the benefits for you and/or your dependents if the Employer has been duly notified with the Notice of Cancellation for Nonpayment of Premiums and Grace Period and billed for the charge and at least a 30-day grace period has elapsed since the date of the receipt of the last premium payment. The notice of cancellation for nonpayment of premiums and grace period shall include the language in California Title 28, Section 1300.65(c)(3)(B)(ii) in be in at least 12 point font:

> *"You are receiving this Notice of Cancellation because your HPCC coverage is being cancelled or not renewed because you have not paid your premium. Even though you have not paid your premiums, you are being provided a "grace period" to allow you time to make your past due premiums payment(s) without losing your health care coverage. "Grace period" means a period of at least 30 days beginning no sooner than the first day after the last day of paid coverage and lasts at least 30 days. Your grace period ends on (insert month, day, year). You may avoid losing your coverage if you pay the premium(s) owed to HPCC before the end of the grace period. If you do not pay the required premium amount by the end of the grace period, your coverage will be terminated effective the day after the last day of the grace period. Your grace period ends on (insert month, day, year). Coverage will continue during the grace period; however, you are still responsible to pay unpaid premiums and any copayments, coinsurance or deductible amounts required under the plan contract. For information about individual health care coverage and health care subsidies that may be available to you, contact Covered California at (800) 300-1506 or TTY at (888) 889-4500 or online at www.CoveredCa.com. If you wish to end your coverage immediately, please contact HPCC as soon as possible."*

Coverage will continue during the grace period; however, the Employer will be still responsible to pay unpaid premiums and the Enrollee will be responsible for any copayments, coinsurance or deductible amounts required under the group plan contract. Grace period means a period of at least 30 days beginning no earlier than the first day after the last date of paid coverage to allow the Employer to pay an unpaid premium amount without losing healthcare coverage. At a minimum this grace period shall extend through the thirtieth (30^{th}) day after the last date of paid coverage.

If HPCC withdraws a health benefit plan from the market, HPCC will notify the Employer, enrollees and the director at least 90 days prior to the discontinuation of the group contract. Notice of the decision to cease new or existing health benefit plans in the state is provided to the director, the Employer and the enrollees covered under this group plan contract at least 180 days prior to the discontinuation of this contract.

HPCC has the right to terminate your coverage under this Plan in the following situations:

- **Failure to Pay.** Your coverage may be terminated for employer's nonpayment of required premiums owed to HPCC if your employer has been duly notified and billed for the charge and at least a 30-day grace period has elapsed since the date of the receipt of the last premium payment. Coverage will continue during the grace period; however, the Employer will be still responsible to pay unpaid premiums and the Enrollee will be responsible for any copayments, coinsurance or deductible amounts required under the group plan contract.

- **Fraud or Misrepresentation.** Your coverage may be terminated if you knowingly provide false information (or misrepresent a meaningful fact) in the enrollment process or fraudulently or deceptively use services or facilities of HPCC and/or its contracted providers (or knowingly allow another person to do the same). If coverage is terminated for the above reasons, you forfeit all rights to enroll in the COBRA Plan and lose the right to re-enroll with HPCC in the future.

Responsibilities of Employer- Cancellation of Contract. Continuing coverage under this Plan is subject to the terms and conditions of the Employer's Group Contract with HPCC. If the Group Contract is cancelled, coverage for you and all your Eligible Dependents will end after a written notice of termination of coverage is given and a 30-day grace period has elapsed since the date of the receipt of the last premium payment. Coverage will continue during the grace period

If an enrollee's eligibility has ended for any of the above reasons, the enrollee will be notified in writing and informed of the effective termination date and information regarding the grace period. Coverage of the enrollee's dependents will end when enrollee's coverage ends. Any enrollee who is undergoing treatment in a hospital for acute care at the time of cancellation will continue to be covered under the terms of the Group Contract until discharge.

It is the responsibility of Employer to notify the enrollee of the termination of this group contract. In the event we provide notice of cancellation, within five business days, for non-payment of premium to the Employer, Employer agrees to promptly mail a legible, true copy of the notice of cancellation to all enrollee at their current address. The notice of cancellation will include:

- Effective date of the cancellation and grace period; the date of the last day of paid coverage

- The reason for cancellation, including reference to the applicable clause in this Agreement;

- The dollar amount due to HPCC

- The date the grace period begins and expires. Grace period means a period of at least 30 days beginning no earlier than the first day after the last date of paid coverage to allow the Employer to pay an unpaid premium amount without losing healthcare coverage. At a minimum this grace period shall extend through the thirtieth (30^{th}) day after the last date of paid coverage.

- The obligations of the enrollee or group contract holder during the grace period (if any)

- A statement that the cause for cancellation was not due to the enrollees health status or requirements for health services;

- That a enrollee who alleges that cancellation was due to the enrollees health status may request a

review of cancellation by the Department of Managed Health Care;

Under no circumstances will an enrollee be terminated due to health status or the need for services. Any enrollee who believes his or her enrollment has been terminated due to health status or required services may request a review of the termination by the California Department of Managed Health Care.

Right to Submit Request for Review of Cancellation, Rescission, or Nonrenewal of Your Plan Contract, Enrollment, or Subscription.

If you believe your plan coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a Request for Review. You have the options of going to the plan and/or the Department if you do not agree with the plan decision to cancel, rescind or not renew your plan coverage.

Option (1) - You may submit a Request for Review to your plan.
* You may submit a Request for Review to HPCC by calling 1-800-321-2843 or submitting a request at www.HolmanGroup.com, or by mailing your written Request for Review to HPCC, P.O. Box 8011, Canoga Park, CA 91309.
* You may want to submit your Request for Review to HPCC first if you believe your cancellation, rescission or nonrenewal is the result of a mistake. Requests for Review should be submitted as soon as possible after you receive the Notice of Cancellation, Rescission, or Nonrenewal.
* HPCC will resolve your Request for Review or provide a pending status within three (3) days. If the plan upholds your cancellation, rescission or nonrenewal, it will immediately transmit your Request for Review to the Department of Managed Health Care and you will be notified of the plan's decision and your right to also seek a further review of the plan's decision by the Department as detailed under

Option 2, below.
Option (2) - You may submit a Request for Review to the Department of Managed Health Care.
* You may submit a Request for Review directly to the Department of Managed Health Care without first submitting it to the plan or after you have received the plan's decision on your Request for Review.
* Requests for Review by the Department of Managed Health Care may be submitted:

By mail:
HELP CENTER
DEPARTMENT OF MANAGED HEALTH CARE
980 NINTH STREET, SUITE 500
SACRAMENTO, CALIFORNIA 95814-2725

BY PHONE:
1-888-466-2219
TDD: 1-877-688-9891
FAX: 1-916-255-5241
OR ONLINE:
WWW.HEALTHHELP.CA.GOV

There is no charge to call. Help is available in many languages.

For a California enrollee whose Cal-COBRA coverage begins on or after December 1st , and who has exhausted continuation coverage under COBRA, the enrollee shall have the opportunity to extend their Cal-COBRA coverage to 36 months after the date the qualified beneficiary's benefits under a group plan contract would otherwise have terminated by reason of a qualifying event.

Benefit Claims Procedures:

Plan participants may access their behavioral health benefit services for emergency and urgent assistance by calling HPCC's toll-free number 24 hours a day, seven days a week: **(800) 321-2843.** To schedule an appointment, plan participants should call the toll-free number during the plan's office hours, Monday through Friday 7:30 a.m. – 5:00 p.m. Pacific Standard Time (PST) and a trained Care Access Specialist will have a qualified network provider who is located in the participant's local area call him/her back directly, usually within 48 business hours of receiving the call, to schedule an appointment. To receive a community referral or for inquiries regarding HPCC's behavioral health services or benefits, the plan participant should call HPCC Monday through Friday 7:30 a.m. - 5:00 p.m. PST. If a plan participant has questions about his/her company's employer benefit plan, he/she should contact **MiraCosta College**, directly at **(760) 757-2121 x6978**. If a plan participant has questions regarding their rights under their company's benefit plan or the Health Insurance Portability and Accountability Act of 1996, plan participants may contact the Department of Labor at **(415) 945-4600** in Northern California or **(626) 583-7862** in Southern California.

Appeals of Denied Claims and Denied Treatment Authorization:

If a plan participant disagrees with the decision to deny treatment authorization or they deny a claim, they are encouraged to contact HPCC directly at **1-800-321-2843.** HPCC will direct the participant's disagreement to the assigned Care Manager. The Care Manager will work together with the participant and a Care Supervisor to resolve the matter. Within thirty (30) days from HPCC's receipt of the grievance, HPCC will send the plan participant a written notice of the resolution. If the request is denied, the plan participant may appeal the Care Manager's decision as follows:

Grievance Process:

HPCC wants you to be satisfied with your behavioral health care services. If a problem arises, we want to help solve it. If a question arises, we want to help you answer it. All enrollees will have reasonable access to the filing of a complaint. Enrollee's **shall have up to 180 calendar** days following any incident or action that is the subject of the enrollee's dissatisfaction to file a grievance with HPCC. Complaints may be reported to any HPCC staff member in person, or by telephone by calling **(800) 321-2843**. Also, complaints may be submitted in writing to **Holman, P.O. Box 8011, Canoga Park, CA 91309,** or via the Plan's secure website at http://www.Holmangroup.com. A HPCC staff member will then immediately direct the complaint to the Compliance Specialist. The Plan's address, telephone number and procedures for initiating complaints are communicated in the enrollee benefit book. Grievance Complaint forms are also available from all Plan providers (Grievance Complaint Forms are included in the initial packet of documents provided to contracted providers). In addition, grievance forms are placed on HPCC's website. Additionally, providers are sent a mailing notification informing them that the grievance forms in their packets should be copied and made available to enrollees upon request or when indicated (via concerns voiced) by the enrollee. Grievance Forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan's website, and from each contracting provider's office or facility. Grievance forms shall be provided promptly upon request. Enrollees will be updated of any revisions to the grievance process-whether it be by sending the updated grievance policy and/or Combined Evidence of Coverage and Disclosure Form detailing the changes in the grievance policy. HPCC shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance.

Expedited Grievance Review. For cases involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, HPCC provides expedited review. When HPCC has notice of a case requiring expedited review, HPCC shall immediately inform the enrollee in writing of their right to notify the Department of Managed Health Care (the "Department") of the request. For these cases, HPCC will provide the enrollee and the Department with a written statement on the disposition or pending status of the request no later than three (3) days from receipt.

California 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 Holman Professional Counseling Centers, Inc., you should first telephone Holman Professional Counseling Centers, Inc. at **(1-800-321-2843)** and use Holman Professional Counseling Centers, Inc., 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 Holman Professional Counseling Centers, Inc., or a grievance that has remained unresolved for more than thirty (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 Holman Professional Counseling Centers, Inc. 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 website **htttp://www.*hmohelp*.ca.gov** has complaint forms, IMR application forms and instructions online.

Arbitration:

If the Enrollee remains dissatisfied with the decision, the Enrollee may submit a request to HPCC to submit the grievance to binding Arbitration before the American Arbitration Employer. Pursuant to California law a single neutral arbitrator who shall be chosen by the parties and who shall have no jurisdiction to award more than $200,000 must decide any claim of up to $200,000. However, after a request for arbitration has been submitted, HPCC and the Enrollee may agree in writing to waive the requirement to use a single arbitrator and instead use a tripartite arbitration panel that includes the two party-appointed arbitrators or a panel of three neutral arbitrators or another multiple arbitrator system mutually agreeable to the parties. The Enrollee shall have three (3) business days to rescind the waiver agreement unless the agreement has also been signed by the Enrollee's attorney, in which case the waiver cannot be rescinded. In cases of extreme hardship, HPCC may assume all or part of the Enrollee's share of the fees and expenses of the neutral arbitrator provided the Enrollee has submitted a hardship application with the American Arbitration Employer. The American Arbitration Employer shall determine the approval or denial of a hardship application. A hardship application may be obtained by contacting the American Arbitration Employer in Los Angeles at 213-383-6516, in Orange County at 714-474-5090, in San Diego at 619-239-3051 and in San Francisco at 415-981-3901.

If the Enrollee does not request arbitration within six months from the date of the Grievance Resolution Notice, the decision of the Committee shall be final and binding. However, if the Enrollee has legitimate health or other reasons which would prevent them from electing binding arbitration in a timely manner, the Enrollee will have as long as necessary to accommodate his or her special needs in order to elect binding arbitration. Further, if the Enrollee seeks review by the Department of Managed Health Care, the Enrollee will have an additional ninety (90) days from the date of the final resolution of the matter by the Department of Managed Health Care to elect binding arbitration. Upon submission of a dispute to the American Arbitration Employer, both the Enrollee and HPCC agree to be bound by the rules of procedure and decision of the American Arbitration Employer. Full discovery shall be permitted in preparation for arbitration pursuant to California Code of Civil Procedure, Section 1285.05.

HIPAA Compliance. HPCC is compliant with all HIPAA privacy requirements. Our HIPAA compliance statement is posted on our website.

HPCC's Public Policy Committee. HPCC operates a Public Policy Committee that is mandated to maintain professional standards. It functions as an open forum to provide enrollees with an opportunity to discuss prevailing societal issues, difficulties with current policies, and additional available services. The purpose of the Public Policy Committee is to ensure the comfort, dignity, and convenience of persons relying upon HPCC for behavioral health care services. In order to assure enrollee participation in Plan policy, the Public Policy Committee shall consist of the following enrollees: Holman Executive Vice President, Director of Corporate Account Management, Account Management staff and a minimum of three current enrollees. The Executive Vice President selects the enrollee enrollees of the Public Policy Committee. Any enrollee interested in the Public Policy Committee may direct their request in writing to: **HPCC, P.O. Box 8011, Canoga Park, CA 91309.**

Language Assistance Program ("LAP"). The Department of Managed Health Care ("Department") of California has added Section 1300.67.04 (Language Assistance Programs) to Title 28 California Code of Regulations. This regulation requires health care service Plans to implement new policies, procedures and quality improvement efforts in regards to assisting those who are Limited English Proficient ("LEP"). The Department regulations require California health Plans to set up a system where services, materials, and information are provided to enrollees in a language that they speak and understand.

In accordance with the Department regulations, HPCC has identified its threshold language(s) which comprise five (5) percent of its enrollee Population. All vital documents as identified by the Department will be translated into the threshold language. All non-vital documents will contain a notice at the bottom of said document (in the threshold language) informing the enrollee how to request a translation of the document.

HPCC has established a free Language Assistance Program ("LAP") and made the following resources available for LEP individuals: Translations (in the threshold languages), Interpreters, and Bilingual staff/providers. These resources are available for all persons who request these services at any of our points of contact.

Antifraud Policy and Procedures. HPCC makes every effort to detect, investigate, and prosecute any incidents of fraud at any level within its behavioral health care service. Fraud hurts everyone through higher taxes to fund government health care plans and higher premiums for private health coverage. In order to insure that our enrollees do not have to pay for the high cost of fraud, we encourage you to report fake claim schemes. We are here to help you recognize and report any incidents or suspected incidents of fraud you discover. If you notice that a claim submitted to HPCC by your provider's office includes a charge for a therapy session you did not receive, you may have detected health care fraud. The first step is to notify your provider of the incorrect charge. The second step is to notify HPCC at **1-800-321-2843.** HPCC wants your help to identify potentially fraudulent or abusive claim activities. If you know or suspect illegal or wrongful billing practices by a provider or an enrollee, please tell us. We will treat any information you provide with strict confidentiality. We promise not to disclose your identity unless you are willing to voluntarily give us your written permission. Furthermore, state and federal laws protect the confidentiality of your medical records. We will not release any medical information without lawful authorization.

HPCC contracts with a special investigator trained in fraud investigation to assist us in investigating

fraud. In the event that HPCC detects any fraudulent activity on the part of a provider, the provider's contract with HPCC will be terminated. If HPCC detects any fraudulent activity on the part of an enrollee, HPCC will deny enrollee any additional benefits under enrollee's Group Health Plan. Additionally, HPCC will prosecute fraud to the fullest extent of the law. We also cooperate with all government agencies in a combined effort to prevent and prosecute fraud on the part of both providers and enrollees.

Organ and Tissue Donation. Approximately 77,000 people in the U.S. are on the national waiting list for an organ. An average of 15 people die every day because not enough organs are available. Organ and tissue transplantation saves lives. For example, about 60 people receive life-enhancing organ transplants each day and about 82% of patients who receive a donated kidney are still alive 5 years later.

For more information on how to become an organ and tissue donor, visit the U.S. Department of Health and Human Services website at www.organdonor.gov or call: 1-888-ASK-HRSA (1-888-275-4772).

DEFINITIONS

1. **Benefits Schedule.** Incorporated by reference. Describes the available levels of treatments provided through a Group Plan Contract, along with required deductibles and co-payments.

2. **Contracted Provider.** A person licensed as a psychiatrist, psychologist, clinical social worker, marriage, family and child counselor, nurse or other licensed health care professional with appropriate training and experience in behavioral health services, and who has contracted with HPCC to deliver specified services to HPCC Enrollees.

3. **Co-payment.** Fixed fee paid pursuant to this Agreement to a Provider by Enrollee at time of provision of behavioral health services, which are in addition to the premiums paid by the Employer/Trust. Such fees may be a specific dollar amount or a percentage of total fees, depending on the type of services provided. The EAP has $0.00 copay.

4. **Covered Services.** EAP services provided by Providers that are determined to fall within the scope of EAP services and covered under the Group Plan Contract.

5. **Employee/Member.** Individual who works for an employer or is a member of a trust, who has contracted with HPCC for behavioral health care services.

6. **Employee Assistance Program (EAP).** The EAP is a confidential service designed to provide employees and their families with experienced counseling professionals for help with personal problems and issues. Additionally, the program offers limited free legal and financial advice and referral, training, and access to helpful online articles. The program is available to employees and their eligible dependents at no cost. **Not a covered benefit.**

7. **Employer.** An organization that has contracted with HPCC to provide behavioral health care services to its eligible employees.

8. **Enrollee.** An eligible employee or trust member (and/or such employee's/member's eligible dependents) of an employer/trust who has contracted with HPCC to provide behavioral health services to its employees/members. Employee/member must meet HPCC's eligibility requirements, enroll in the employer/trust's Group Plan, and accept the financial responsibility for any co-payments that may be incurred in treatment through the Group Plan.

9. **Family Unit.** Comprised of Enrollee plus Enrollee's eligible dependents.

10. **Group Plan Contract.** Agreement between an Employer/Trust and HPCC providing that HPCC will provide behavioral health care services for the Employer/Trust's eligible employees/members in exchange for Premium paid by the Employer/Trust.

11. **Premium.** Predetermined monthly membership fee paid by an employer/trust for coverage under the Group Plan Contract.

12. **Provider.** A person licensed as a psychiatrist, psychologist, clinical social worker, marriage, family and child counselor, nurse or other licensed health care professional with appropriate training and experience in behavioral health services, working individually or within a corporation, clinic, or group practice, who is employed or under contract with HPCC to deliver supplemental mental health and substance abuse services to Enrollees.

EXHIBIT C

RATE INFORMATION

Supplemental Mental Health & Substance Abuse Services: $26.84 pepm

For plan design information, please see Exhibit A of this agreement.

Rates above Guaranteed for (18) eighteen months effective 7/1/2023 to 12/31/2024.