Association of Los Angeles Deputy Sheriffs (ALADS)

Evidence of Coverage And Disclosure Form (EOC) Mental Health/Substance Use Services

Members on the Anthem Blue Cross CaliforniaCare HMO
Effective January 1, 2025

Holman Professional Counseling Centers
Managed Behavioral Healthcare Services

Holman Professional Counseling Centers
P.O. Box 8011
Canoga Park, California 91309
Tel: (855) 345-1648
Fax: (818) 704-9339
www.holmangroup.com

Combined Evidence of Coverage & Disclosure Form

This Combined Evidence of Coverage and Disclosure Form (EOC) constitutes only a summary of the Group Plan Contract, which has been entered into between your Association, hereafter called "Association" and Holman Professional Counseling Centers, hereafter called "Holman", the "Plan", or "The Holman Group." The Group Plan Contract must be consulted to determine the exact terms and conditions of coverage. A copy of the Group Plan Contract will be presented to you by Holman or your Association upon request.

This EOC discloses the terms and conditions of coverage. Any applicant has a right to view the EOC prior to enrollment. This EOC will be furnished by Holman to the Association who will then distribute it to Enrollees. Every Enrollee should read this EOC completely and carefully. Enrollees with special health care needs should read the sections that apply to them carefully.

This EOC shall be presented to all group representatives at the time of the Group Plan Contract's examination for sale. All Group Plan Contract holders shall disseminate copies of this completed EOC to all eligible Applicants at the time those persons are offered the Plan. Where the Group Enrollees are offered a choice of plans, separate EOCs shall be supplied for each plan available.

When an Enrollee has a need for care in an area that has a shortage of one or more types of providers, Holman shall ensure timely access to covered health care services by referring Enrollees to available and accessible contracted providers in neighboring areas consistent with patterns of practice for obtaining behavioral health care services in a timely manner appropriate for the Enrollee's needs. Also, in any such area where the plan's broad network has a pocket of no access for an Enrollee wanting to access services, Holman will immediately locate a suitable provider/facility and arrange a Letter of Agreement (LOA) with such provider/facility. Additionally, should the services being requested be above and beyond what a Letter of Agreement entails, the Plan will immediately recruit and fully contract with providers/facilities to provide services for the Enrollees. This action will ensure that the Enrollee has appropriate access to care as well as guarantee that the Enrollee will only be responsible for their applicable co-payments, co-insurance, and deductibles.

The period of coverage for this Combined Evidence of Coverage and Disclosure Form is January 1, 2025 to December 31, 2025.

This EOC incorporates by reference and includes as part of the total Agreement, those benefits and coverages outlined in the Group Contract and Benefit Schedules. If you have any questions about your benefits or how to use them, please contact:

Holman Professional Counseling Centers
P.O. Box 8011
Canoga Park, CA 91309
(855) 345-1648
www.holmangroup.com

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ELIGIBILITY

Who Is Eligible?
All members covered under their Association's Group Plan and their eligible dependents (referred to collectively as "Enrollees" except where otherwise indicated) may enroll with Holman if they meet the eligibility requirements defined by the Association and Holman as stated in the Group Plan Contract.

Who Is an Eligible Dependent?

Includes the Subscriber's lawful spouse, domestic partner (as defined in Section 297 of the Family Code) children to age twenty-six (26). Children include stepchildren, adopted children, and foster children, regardless of whether they are dependent upon the Subscriber 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 twenty-six (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 physically or mentally disabling injury, illness, or condition.

What If My Dependent Is Also A Covered Enrollee?
An Enrollee may not be covered as a Subscriber and as a dependent on a plan and Enrollee's dependents may not be covered by more than one Plan. If a Subscriber is also a dependent of a Subscriber, the Subscriber will be insured solely as a Subscriber and all copayments will be waived. 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.

When Does Coverage Begin?
Coverage begins on January 1, 2025 at 12:00 a.m. The period of coverage for this EOC for an individual Enrollee will not begin prior to the expiration of any waiting period imposed by the Association.

Reinstatement Due to Employment Status.
If a Subscriber is terminated from association membership status and he or she returns to active status as an active member, such Subscriber and his or her eligible dependents may again become eligible.

USING THE HOLMAN PLAN

In order to assist Enrollees with accessing services described in this Combined Evidence of Coverage and Disclosure Form, each Enrollee will be provided an identification card to be distributed to the covered Enrollees. Holman will provide your Association Group with identification cards to be distributed to the covered Enrollees.

Step 1:
Holman wants to provide the best service possible to its Enrollees. Holman can be reached twenty-four (24) hours a day, seven (7) days a week. Just dial Holman's toll-free number, **(855) 345-1648**, to talk to a Holman representative. Tell the Holman representative that you are an Enrollee and the name of the Subscriber's Association. The Holman representative will gather basic information about you. You may obtain a list of available contracted providers at www.HolmanGroup.com. Once a Holman contracted provider has been selected from the Holman Website, Holman must be called and informed

of the provider(s) selected by the Enrollee in order to obtain a required pre-authorization for the service(s) with the chosen provider(s).

Our Plan has free interpreter services available to answer questions from disabled and non-English speaking Enrollees. This information is available for free in other languages. Please contact our Care Access Department at **(855) 345-1648** (English TTY (800)735-2929 and TTY Spanish (800)735-2922).

Step 2: Emergencies, crisis, or urgent care

If you have a medical emergency, you should dial "911" for the emergency response system if such an emergency service is established and operating in your area. If it is a **behavioral health emergency**, you must contact Holman as soon as reasonably possible. Holman must coordinate continuing and follow-up behavioral health services to emergency treatment. Holman may elect to transfer you to a Holman provider if such transfer would not create any unreasonable risk with your care. Holman handles emergencies immediately upon contact. To determine whether the Enrollee does or does not have a medical emergency, Holman will take into consideration whether the Enrollee's belief was reasonable. For information regarding emergency services relating to Behavioral Health Services Emergency Treatment Benefit, please see sections B, and C, in Exhibit A on pages 35-38.

Step 3:

As stated in Step 1 above, if you have a non-emergency, you must call Holman and explain the service you are interested in utilizing or the problem you are experiencing. The Holman representative will ask you a series of questions to determine what treatment is Medically Necessary. Regular appointments are booked within a few working days of your call. A Holman representative will call you back in most cases the same day you call in and schedule your appointment with a provider. All authorizations for non-emergency care will be decided within five (5) working days of the request. Upon Enrollee request, Holman will disclose its processes, including criteria and general requirements for, authorizing, modifying, or denying services.

Step 4:

After the initial session(s) with a Holman provider, the provider will fill out a clinical assessment on you and return it to Holman's Outpatient or Inpatient Care Department. Holman's Outpatient or Inpatient Care Department will review the clinical assessment. If your care is complete, your case will be turned over to Holman's Utilization Review Department for record-keeping and quality assessment. If you require further treatment, Holman's Utilization Review Department will send out a renewal form to the provider. The provider will return the renewal form to the Outpatient or Inpatient Care Department with future treatment recommendations to the Outpatient or Inpatient Care Department.

Step 5:

Holman's Outpatient/Inpatient Care Department will review the treatment recommendation and approve the next set of sessions based on Medical Necessity. In the event a peer review is necessary, one of our Behavioral Health Care Advisors or Medical Director will speak with your treating provider. If future outpatient care is not Medically Necessary, your file will be turned over to Holman's Utilization Management Committee (UMC) for a second review. If future inpatient care is not Medically Necessary, your file will be turned over to Holman's Medical Director for a second review. The UMC or Medical Director will review, discuss, and assess your previous treatment and ensure that Medical Necessity decisions were based on appropriate objective standards. If the UMC or Medical Director determines that more treatment is Medically Necessary, the treatment will be authorized within five (5) working days of the request. If the UMC or Medical Director determines that more treatment is not Medically Necessary, the treatment will be denied, you will be notified in writing of the reasons

for the denial and be informed of the right to file a grievance with the Plan. Emergency Behavioral Health Services and Care will be available on a 24-hour-per-day, 7-day-per-week basis. Inpatient, residential, and partial day care services shall be provided by Hospitals or Sub-Acute Care Facilities under contract with Holman. Emergency Behavioral Health Services and Care do not require Prior Authorization.

GENERAL PROVISIONS

Prepayment Fees. The Association will pay monthly fees for each eligible Enrollee as stipulated in the Group Contract Agreement. These fees are renewable and negotiated as per the language in that same Agreement.

Cost-Sharing/Copayments/Deductibles and Out-of-Pocket Maximums. Enrollee and Enrollee's eligible dependent(s) are responsible for the Cost-Share amounts specified in the attached Benefits Schedule (*see page __ for the Benefit Schedule information*). The Cost-Share may be a specific dollar amount or a percentage of the provider's charge depending on the service provided. The Enrollee will not be liable for any sums owed to the provider by Holman should Holman default under the terms of its Provider Agreement. Holman and the medical plan have systems in place so Enrollees have one (1) accumulated deductible and one (1) Out-of-Pocket Maximum amount for both medical and behavioral health Covered Services. Holman exchanges timely data with your primary medical plan. Please contact Holman at **(855) 345-1648** for any questions or additional information.

Confidentiality. 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 YOU UPON REQUEST.

Choice of Physicians and Providers.
PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

A Holman Clinician or Care Access representative will refer you to Holman providers in your community. Enrollees and consumers can access www.HolmanGroup.com to search for a Contracted Provider. If the Enrollee uses a Non-Contracted Provider, the Enrollee is responsible for arranging for services to be rendered and for any charges incurred except as outlined in the Benefits Schedule, in the event of Emergency Behavioral Health Services and Care, or as Prior Authorized by Holman. (See Exhibit A, pages 35-39).

When an Enrollee has a need for care in an area that has a shortage of one or more types of providers, Holman shall ensure timely access to Covered Services by referring Enrollees to available and accessible Contracted Providers in neighboring areas consistent with patterns of practice for obtaining Covered Mental Health Services in a timely manner appropriate for the Enrollee's needs. Also, in those rare instances where Holman's broad network has no access for an Enrollee wanting to access Covered Mental Health Services, Holman will immediately attempt to locate a suitable provider/facility and arrange a Letter of Agreement with such provider/facility. This action will ensure that the Enrollee has

appropriate access to care as well as guarantee that the Enrollee will only be responsible for their applicable in-network Cost-Share.

Facilities/Provision of Services. Holman provides behavioral health services (See Exhibit A, pages 35-39) through providers pursuant to the Schedule of Benefits (see Exhibit A, pages 35-39). If an Enrollee wishes to use a Contracted Provider, such Enrollee may call Holman at (855) 345-1648. Holman will then assign the Enrollee to an appropriate Contracted Provider based upon intake information that Holman will request in its conversation with the Enrollee. Enrollees and consumers can access www.HolmanGroup.com to review our provider directory and may select any Contracted Provider that is accepting new patients. Once a Holman Contracted Provider has been selected from the Holman website, Holman must be informed of the Contracted Provider's name by the Enrollee. If the Enrollee wishes to use a Non-Contracted Provider, the Enrollee does so at his or her own expense except for Emergency Behavioral Health Services and Care or as Prior Authorized by Holman. Emergency Behavioral Health Services and Care are available on a twenty-four (24)-hour-per-day, seven (7)-day-per-week basis. Inpatient, residential, and partial day care services shall be provided by Hospitals or Sub-Acute Care Facilities under contract with Holman. Emergency Behavioral Health Services and Care do not require Prior Authorization by Holman.

Concurrent Reviews. In order to determine the continuing medical necessity for your treatment, concurrent reviews will occur on a regular basis. During such reviews, a Holman clinician monitors the course of treatment to determine its effectiveness and the appropriateness of the level of care and continued Medical Necessity. The Holman clinician must authorize all extended lengths-of-stay and transfers to different levels of care as well as any related additional services.

Process and Criteria.

Summary of Utilization Management Process, Guidelines and Criteria

Holman is committed to providing high quality mental health services and strives towards excellence in customer service. It is our desire to help Enrollees to reduce functional impairments and to improve daily functioning quickly. It is also our goal to deliver quality and cost-effective mental health services through the effective use of resources while measuring outcomes and satisfaction via continuous quality improvement methodologies.

The function of Utilization Management is to facilitate the provision of quality, efficient mental health services to Enrollees and providers through monitoring, evaluating, and influencing the processes and behaviors, which impact the delivery of services. The criteria used to determine whether to authorize, modify, or deny mental health care services are developed with 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 you are guidelines used by Holman 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 Covered Services under your plan. Managing the treatment patterns of the delivery systems for maximum efficiency is the overall goal of Utilization Management.

Accessing Services and Marketing Referrals

The Holman Group Covered Services (inpatient, detoxification, alternative care, and outpatient services) require Prior Authorization, except for Emergency Behavioral Health Services and Care. In the case of Emergency Behavioral Health Services and Care, it is required that the facility, provider, or an Enrollee or their representative contact Holman on the following business day or as soon as

reasonably possible to notify a Holman Behavioral Health Care representative of the Emergency Behavioral Health Services and Care.

Providers seeing patients who need to make additional referrals for that patient (such as an MFT provider referring a patient to a psychiatrist) must contact a Holman Behavioral Health Care representative for that patient, giving justification for the referral request. If the referral is determined appropriate, the Behavioral Health Care representative will make the assignment to the new/additional provider, relaying pertinent information about the patient, and will ensure that the appropriate Prior Authorization is provided.

Specific care and treatment may vary depending on individual need and the Covered Services under your plan.

The clinical review guidelines and Change Healthcare, formerly McKesson, criteria utilized by Holman are based on national standards for mental health professional practice, which include the fields of psychiatry; clinical psychology; clinical social, marriage, family and child counseling; and psychiatric nursing. These guidelines are developed using clinical resources from (but not limited to) the American Psychiatric Association, American Medical Association, American Psychological Association, National Institute of Mental Health, National Institute of Alcohol Abuse and Alcoholism, and the National Institute of Drug Abuse.

These guidelines define the general criteria used to determine the level of care and type of treatment needed for each case. Establishing Medical Necessity and level of care is required to effectively treat an Enrollee's needs. Authorization decisions are also influenced by the unique characteristic of each individual benefit package (which determine the Covered Services), and the specific limitations of each plan (please refer to your schedule of benefits Exhibits A, pages 35-38).

Implicit in these guidelines is the Holman Group's goal to provide the most effective, appropriate level of care in the least restrictive (intensive) environment, and within the benefit package purchased by the Association. This also requires that all Enrollees have ready access to the Covered Services they need and that they receive quality treatment.

Medical Necessity
The central consideration in all Holman Group clinical review decisions and authorizations is the determination of the most appropriate and Medically Necessary level of care. Clinical information gathered by The Holman Group's care management staff is aimed at satisfying this consideration.

The following conditions must be present in order to meet the criteria for Medical Necessity:

- **a)** Services must be consistent with professionally recognized standards of practice and are essential for the evaluation and treatment of a disease, condition, or illness, as defined by standard diagnostic nomenclatures (DSM 5, ICD-10);
- **b)** Treatment can be reasonably expected to improve an individual's condition or level off functioning, maintain and individual's condition or level of functioning, or prevent a relapse;
- **c)** Must be standard mental health practice where received for the condition being treated and must be legal in the United States; and
- **d)** Are provided at the most cost-effective level of care that is appropriate to the clinical needs of the Enrollee.

To maintain Authorization of Covered Services, all four elements of Medical Necessity must be present throughout the course of treatment.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment that can be provided ONLY on an Inpatient basis. Holman will determine whether the above requirements have been met based on: (1) published reports in authoritative, peer-reviewed medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), and/or (3) Physician Specialty Society recommendations.

The function of Utilization Management is to facilitate the provision of quality appropriate and efficient behavioral health services to Holman Enrollees through monitoring, evaluating, and influencing the processes and behaviors, which impact the delivery of services. Managing the treatment patterns of the delivery systems for maximum efficiency is the overall goal of Utilization Management. The Utilization Management policies and procedures are used to authorize, modify or, when necessary, deny mental health care services under the benefits provided by Holman. The Holman Utilization Management procedures can be accessed on www.HolmanGroup.com or upon request by calling Holman at **(855) 345-1648.**

Enrollee Reimbursement Provisions. Holman has made arrangements with its Contracted Providers to ensure that all bills are submitted directly by the provider to Holman for payment. If an Enrollee receives any behavioral health treatment from a Non-Contracted Provider, the Enrollee may receive a bill for such services and therefore will need to submit the bill to Holman at the address below. Enrollees receiving Emergency Behavioral Health Services and Care from Non-Contracted Providers must provide Holman with a bill or claim no later than one hundred and eighty (180) days from the first date of service. Every effort will be made to ensure Enrollees are not subject to balance billing practices for Covered Services paid under the Holman Agreement. Enrollees may be liable for the cost of Non-Emergency Behavioral Health Services and Care provided by Non-Contracted Providers. In the event Holman fails to pay Non-Contracted Providers, the Enrollee may be liable to the Non-Contracted Provider for the cost of services. Contracted Providers must provide Holman with a copy of the bill or claim no later than ninety (90) days from the first date of service. Non-Contracted Providers must provide Holman with a copy of the bill or claim not later than one hundred and eighty (180) days from the first date of service. Reimbursement is paid according the Enrollee's benefit plan (see Exhibit A, pages 35-39). Providers/Enrollees should mail claims to: **The Holman Group, P.O. Box 8011, Canoga Park, California 91309.**

Provider Compensation Procedure. Holman Contracted Provider hospitals, acute care, sub-acute care, and transitional care are all paid on a discounted fee-for-service or a fixed charge per day for hospitalization. Holman does not use or permit any type of financial bonuses or incentives in its contracts with Contracted Providers. By statute, every contract between Holman and a provider shall provide that in the event Holman fails to pay the provider, the Enrollee shall not be liable to the provider for any sums owed by Holman. If an Enrollee wishes to know more about reimbursement procedures, call Holman at **(855) 345-1648**.

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 **(855) 345-1648**. If the Enrollee's current

provider is not a Holman Contracted Provider, Holman will arrange for an appropriate transition of the Enrollee's care to a Holman Contracted Provider.

Continuity of Care for New Enrollees for Mental Health Coverage. In order to ease transitions of care, new Enrollees who meet the requirements below will be provided with Continuity of Care. At the request of the Enrollee, Holman will provide Continuity of Care through a transitional period at the benefit levels described in this EOC. Holman will provide Continuity of Care for new Enrollees who are in treatment for an acute or serious chronic condition at the time of enrollment, not to exceed twelve (12) months from the effective date of coverage. Financial arrangements with providers that are not contracted with Holman are negotiated on a case by case basis. All efforts will be made for Enrollees utilizing Inpatient Behavioral Health Services to continue to have Continuity of Care without disruption of those services. Behavioral Health procedures that are part of a documented course of treatment and that have been recommended by the provider to occur within one hundred eighty (180) days of the contract's termination date or within one hundred eighty (180) days of the effective date of coverage for the newly covered Enrollee, will be authorized by Holman. Holman will request that Non-Contracted Providers accept the same reimbursement and contractual requirements that apply to Holman Contracted Providers, including payment terms. If the Non-Contracted Provider does not agree to accept said reimbursement and contractual requirements, Holman is not required to continue that provider's service. Review procedures will be provided to all eligible Enrollees upon request. Enrollees may contact Holman directly at **(855) 345-1648** for assistance with Continuity of Care.

Continuity of Care for Enrollees Receiving Services at the Time of a Terminated Provider. In order to ease transitions of care for current Enrollees when a Contracted Provider is terminated, Continuity of Care services will be provided, subject to the requirements below. At the request of an Enrollee who is undergoing treatment for an acute or serious chronic condition at the time of a Contracted Provider termination, Holman will arrange for the continuation of Covered Services for a limited time with that terminated Contracted Provider, as long as the provider's termination was not for medical or criminal disciplinary action. Holman will furnish the Enrollee with behavioral health care from the terminated Contracted Provider for a period of time consistent with good professional practice, not to exceed twelve (12) months from the contract termination. Holman will request that terminated Contracted Provider continue to agree to the existing contractual requirements including those regarding reimbursement and payment terms. Holman is not required to continue to cover Continuity of Care services if the terminated provider will not agree to accept these requests.

At the request of an Enrollee, Behavioral Health procedures that are authorized by Holman as part of a documented course of treatment and that have been recommended and documented by the terminated Contracted Provider to occur within one hundred eighty (180) days of the contract's termination, will be provided as completion of covered services . For maternal mental health conditions, upon the request of the Enrollee, Holman will provide for completion of those Covered Services subject to the requirements below. For an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. To request completion of care services from a terminated Contracted Provider, the Enrollee must contact Holman at **(855) 345-1648**.

In order for a terminated Contracted Provider to continue treating Holman Enrollees during a transition period the provider must agree in writing to:

a) provide or continue to provide the Enrollee's treatment and follow-up care;

b) continue to share information regarding the treatment plan with Holman;
c) accept or continue to accept Holman rates/fee schedules; and in the case of a terminated provider to:
d) continue to abide by the terms and conditions of the prior contract.

Coordination of Benefits. All of the benefits provided under this Plan contract are subject to coordination of benefits, which will be handled in compliance with all applicable requirements.

Charges for Missed Cost-Sharing Sessions* (Contracted Providers Only*).
For Cost-Sharing Sessions, Enrollees will be charged the applicable Cost-Share or the sum of thirty-five dollars ($35.00) (whichever is greater), which must be paid directly to the Contracted Provider for any appointment made with a Contracted Provider that is not kept, except in the case where the Contracted Provider is notified of cancellation 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.

Benefits for Pervasive Developmental Disorder or Autism. Behavioral Health Treatment ("BHT") for Pervasive Developmental Disorder or autism is only covered if a functional behavioral assessment by a licensed Physician or Psychologist has been completed and the BHT has been Prior Authorized by Holman. Behavioral Health Treatment services must be overseen and provided only by Qualified Autism Service Providers, Qualified Autism Service Professionals, and/or Qualified Autism Service Paraprofessionals. Behavioral Health Treatment services covered under this plan are subject to the same Cost-Sharing that applies to services provided for other covered conditions. For example, if delivered in an Outpatient office setting, Behavioral Health Treatment will subject to Cost-Sharing that applies to Outpatient office visits. If delivered in an Inpatient or facility setting, such as the outpatient department of a Hospital, Behavioral Health Treatment Services will be subject to Cost-Sharing that applies to Inpatient or facility benefits.

Liability of Enrollee for Payment for Prior Authorized Services.
CALIFORNIA LAW PROVIDES THAT ENROLLEES ARE NOT LIABLE FOR ANY AMOUNT OWED BY HOLMAN TO ANY CONTRACTED PROVIDER IN THE EVENT HOLMAN DOES NOT PAY FOR AUTHORIZED SERVICES. Authorized treatment by a Contracted Provider shall not be rescinded or modified after the provider renders the service in good faith pursuant to the Authorization.

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

a) The reasonableness or necessity of recommended treatment is questioned;

b) The diagnosis or treatment plan is questioned;

c) Clinical indications are not clear or are complex and confusing; or

d) The 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 timely delivered to the individual who requested the second medical opinion. In an emergency situation, the second opinion shall be rendered within seventy-two (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 Cost-Sharing. If the request for a second opinion is denied, the Enrollee will be notified in writing of the reason(s) for the denial and shall be informed of the right to file a grievance with Holman. The request for a second medical opinion can be made by calling Holman at **(855) 345-1648**, or by writing to:
The Holman Group, Care Management Department, P.O. Box 8011, Canoga Park, California 91309.

Renewal Provisions. The Group Plan Contract between the Association and Holman is for a term of one (1) year unless otherwise indicated. Unless terminated through one of the methods included in "Termination of Benefits" below, the Group Plan Contract will be renewed annually at such rates and upon such terms as may be agreed upon by the Holman and the Association at the time of renewal. The Association will notify Enrollees of any change to the Group Health Plan thirty (30) days prior to the effective date of change.

Termination of Benefits.

Premium Payments

The monthly Premiums for a Group Plan are stated in the Group Plan Contract. Holman will provide the Association with information regarding the Premiums amount and by when payments must be made for coverage to remain in effect. The Association will receive notice of changes in Premiums at least sixty (60) days prior to the change. The Association will notify the Subscriber immediately.

If the Association fails to pay Holman the Premium amounts owed, Holman may cancel this coverage, subject to applicable grace period requirements. If the Association fails to pay the required Premium when due, coverage will terminate the day following the thirty (30)-day grace period. The Association will be liable for all Premiums accrued while this coverage continues in force, including those accrued during the grace period. Holman will send the Association and Subscriber a Notice of End of Coverage no later than five (5) calendar days after the date coverage ends.

Date Coverage Ends

Coverage for a Subscriber and all of their Dependents ends at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the Group Health Service Contract is discontinued; (2) the last day of the month in which the Subscriber's employment terminates, unless a different date has been agreed to between Holman and the Association; (3) the date as indicated in the Notice of End of Coverage that is sent to the Association; or (4) the last day of the month in which the Subscriber and Enrollee become ineligible for coverage, except as provided below.

Termination Due to Eligibility

Even if a Subscriber remains covered, their Dependents' coverage may end if a Dependent becomes ineligible. A Dependent spouse becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment, or dissolution of marriage from the Subscriber; coverage ends on the last day of the month in which the Dependent spouse became ineligible. A Dependent Domestic Partner becomes ineligible upon termination of the domestic partnership; coverage ends on the last day of the month in which the Domestic Partner becomes ineligible. A Dependent child who reaches age twenty-six (26) becomes ineligible on the last day of the month in which their twenty-sixth (26th) birthday occurs, unless the Dependent child is disabled and qualifies for continued coverage as described in the definition of Dependent.

Enrollees can also have their coverage terminated if they live or work outside of the Holman service area. This section does not apply to a minor subject to a qualified child medical support order. Please see the "Eligibility" section above for more information.

Additionally, Holman has the right to terminate your coverage under this Plan in the event the Plan can demonstrate fraud or an intentional misrepresentation of material fact under the terms of this EOC by an Enrollee. If your coverage is terminated under these circumstances, you will receive **thirty (**30**)** days; notice prior to the cancellation or non-renewal.

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 Request Review of Rescission, Cancellation, or Nonrenewal of Your Enrollment or Subscription.

If you believe that your health plan enrollment has been, or will be, improperly rescinded, canceled, 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 of Managed Health Care if you do not agree with the Plan's 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 Holman by calling **(855) 345-1648** or submitting a request at www.HolmanGroup.com, or by mailing your written Request for Review to The Holman Group, P.O. Box 8011, Canoga Park, CA 91309.
- You may want to submit your Request for 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

Online:
WWW.DMHC.CA.GOV

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

Individual Continuation of Benefits.

Federal COBRA Provisions

An Enrollee or Enrollee's dependents may choose to continue coverage under the agreement if coverage would otherwise end due to a Qualifying Event, listed below.

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 provides for the continuation of health insurance coverage for eligible Enrollees and their dependents, of Associations with twenty (20) and over eligible members, for a defined period of time after certain qualifying events occur. Ordinarily, an Enrollee's benefits will cease when the Association'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 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 qualifying event is limited to the following: death of covered Enrollee; termination of employment or reduction in hours of the covered Enrollee's 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 shall, upon election, be able to continue his or her coverage under the Association's 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 Association 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 Association 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.

The failure to notify the Association within the required sixty (60) days will disqualify the qualified beneficiary from receiving continuation coverage under COBRA provisions. An Enrollee electing continuation coverage shall pay to the Association, 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, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the Association within forty-five (45) days of the date the qualified beneficiary provided written notice to the Association of the election to continue coverage, in order for coverage to be continued under COBRA provisions.

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 terminates 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 the Association in writing and pay to the Association 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. A qualified Enrollee can request Cal-Cobra at the conclusion of their Federal Cobra benefits, as 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 members, and their dependents, of Associations with two (2) to nineteen (19) eligible members 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 thirty-six (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 or reduction in hours of the covered Enrollee's 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 Association within sixty (60) days of the date of the qualifying event. Failure to make such notification within the required sixty (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 Association within the sixty (60)-day period following the later of (1) the date that the Enrollee's coverage under the group benefit plan 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 benefit plan.

A qualified beneficiary electing continuation shall pay to their Association 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 one hundred and ten percent (110%) of the applicable rate charged for a covered member or, in the case of dependent coverage, not more than one hundred and ten percent (110%) 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 Association an amount no greater than one hundred and

fifty percent (150%) of the group rate after the first eighteen (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 their Association within forty-five (45) days of the date the qualified Enrollee provided written notice to their Association 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 correct Premium amount within the forty-five (45) - day period will disqualify the qualified beneficiary from receiving continuation coverage. In the event the qualified Enrollee does not receive information from their Association, 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 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 their Association in writing and pay to the Association the required Premium payments. The continuation 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.

For more information on how to extend their Cal-COBRA coverage, the Enrollee should contact Holman by phone at **(855) 345-1648**, or in writing at: **The Holman Group, P.O. Box 8011, Canoga Park, CA 91309.**

Conditions and Procedures for Disenrollment. Holman will assist an Enrollee who elects to disenroll from their respective Association's Holman group plan coverage. The Enrollee must notify Holman in writing of his or her desire to disenroll from the group plan and to discontinue benefits coverage under that group plan contract. Upon receiving the Enrollee's written notification, Holman will promptly take the appropriate steps to disenroll the Enrollee and to discontinue any future benefits. Holman will notify the Enrollee in writing within thirty (30) days that the Enrollee has been disenrolled and all benefits discontinued.

EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations do not apply to Medically Necessary Covered Services to treat severe mental illnesses (SMI) or serious emotional disturbances of a child (SED). Unless otherwise indicated, all exclusions apply to Outpatient and Inpatient Services. Please call Holman with any concerns at (855) 345-1648.

All services must be Medically Necessary in order to be covered. Holman qualified personnel determine Medical Necessity, in accordance with professionally recognized standards of practice and subject to the DMHC's Independent Medical Review process. If a service is delayed, denied, or

modified for lack of Medical Necessity, you may appeal the decision through the grievances and appeals process described above.

All Holman Covered Services that must receive Prior Authorization prior to coverage must be Prior Authorized by Holman, not the medical plan.

1. Late Appointment Cancellation and No-Show Fees.
   For Cost-Sharing Sessions, Enrollees will be charged the applicable Cost-Share or the sum of thirty-five dollars ($35.00) (whichever is greater), which must be paid directly to the Contracted Provider for any appointment made with a Contracted Provider that is not kept, except in the case where the Contracted Provider is notified of cancellation 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.

2. Services provided by Non-Contracted Providers except for those that qualify as Emergency Behavioral Health Services and Care or that are otherwise Prior Authorized by Holman are not a Covered Service. Enrollees may be liable to a Non-Contracted Provider for the cost of services if services provided by the Non-Contracted Provider are not Prior Authorized by Holman (unless they are Emergency Behavioral Health Services and Care that do not require Prior Authorization).

3. Services received prior to or after your effective date of coverage with Holman are not covered unless allowed under the Continuity of Care circumstances described above.

4. Travel expenses, including room and board, even if the purpose is to obtain a Covered Service.

5. Expenses incurred obtaining copies of medical records.

6. Treatments that do not meet national or other applicable standards for behavioral health professional practice are not a Covered Service.

7. Treatment sessions provided by computer Internet services are not a Covered Service unless Prior Authorized by Holman.

8. Coverage for Emergency Behavioral Health Services and Care medical transportation services is covered under the Enrollee's medical plan—please see the medical plan's EOC for more information. Non- Emergency Behavioral Health Services and Care ambulance services are not a Covered Service unless Prior Authorized by Holman for transfer only.

9. Psychological examination, testing or treatment for the following purposes: a. licensing; b. insurance, judicial or administrative proceedings, including, but not limited to, parole or probation proceedings; or c. satisfying an Employer's, prospective Employer or other party's requirements for obtaining employment.

10. 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 under this Agreement.

11. Academic or educational testing. Including services to remedy an academic or educational problem or in an academic or school setting are not a Covered Service. Additionally, no services are covered if provided in an academic or school setting. BHT is only covered if provided in the home or a non-school provider facility. BHT services rendered to provide respite, day care, or Educational Services, or reimbursement to a parent for participating in the treatment are not Covered Services.

12. Psychotherapy used as professional training and not for the treatment of a medical or Mental Health condition is not a Covered Service.

13. Use of a sexual surrogate, sexual treatment of sexual offenders or perpetrators of sexual violence are not a Covered Service. Reporting to the court and interacting with the court are not Covered Services under this Agreement.

14. Pastoral or spiritual counseling, except if delivered by a licensed therapist, is not a Covered Service. Life coaching is not a Covered Service.

15. Dance, poetry, recreation, music, activity, play or art therapy are not Covered Services. Wilderness programs, therapeutic boarding schools, and equestrian/hippotherapy are not Covered Services.

16. Group homes (except Medically Necessary residential treatment Prior Authorized by Holman).

17. Experimental or investigational therapies that have not been approved by the federal Food and Drug Administration, that are not Medically Necessary, and that have not met all applicable Prior Authorization requirements are not Covered Services.

18. All outpatient and inpatient non-prescription and prescription drugs prescribed in connection with an Enrollee's treatment are not a Covered Service under this Plan, including but not limited to methadone and suboxone. Check the medical plan coverage for information regarding prescription coverage.

19. Therapy specifically for the sole purpose of consciousness raising. Hypnotherapy must be provided by a license therapist and be Prior Authorized by Holman.

20. Surgery, anesthesia, acupuncture, physical therapy, speech therapy, and occupational therapy are not Covered Services under this Plan. Please see your medical coverage for more information.

21. Neurological services and tests, including but not limited to EEGs, Pet scans, beam scans, MRIs, skull X-rays, and lumbar punctures are not Covered Services.

22. Inpatient treatment for substance abuse does not cover smoking cessation. Smoking cessation programs are Covered Services on an outpatient basis only.

23. Work, career, employment, or professional related evaluations, treatments, or counseling for non-medical purposes are not Covered Services. Educational Services including, but not limited to, for employment or professional purposes, are not Covered Services.

24. The acute care hospital benefit is limited to Emergency Behavioral Health Services and Care only. Emergency Behavioral Health Services and Care Covered Services include all Hospital treatment and Hospital ancillary services necessary to stabilize a Psychiatric Emergency Medical Condition, as described in the Definitions section. Prior Authorization is not required for Emergency Behavioral Health Services and Care Covered Services. Services performed in any emergency room that are not directly related to the treatment of a Mental Disorder, in accordance with professionally recognized standards of practice, are not Covered Services. Non-Psychiatric Emergency Medical Condition services provided in an emergency setting may be covered by the Enrollee's medical plan coverage.

25. Biofeedback, neuro feedback or electroconvulsive therapy (ECT) must be Prior Authorized by Holman.

26. Anorexia Nervosa/Bulimia Nervosa. Anorexia nervosa and Bulimia nervosa is limited to the psychological factors and disturbances in eating disorders. Medical conditions resulting from eating disorders are not a covered benefit.

27. Treatment by a provider other than those within licensing categories recognized by Holman as providing medically necessary services in accordance with professionally recognized standards of practice.

28. Mental Health and Substance Abuse Inpatient or subacute or residential admissions, must be recommended or approved by a Medical Doctor (M.D.) who is also a Psychiatrist or a Doctor of Osteopathy (D.O.), who specializes in mental health, including substance abuse disorders, unless otherwise Prior Authorized by the Plan.

29. Any expense not recommended and approved by a behavioral health professional acting within the scope of his or her license or by a Qualified Autism Service Provider (including but not limited to registered mental health interns, pastoral and spiritual services, and life coaches).

30. Mental health emergency visits at home unless Prior Authorized by Holman.

31. Other psychological testing, except to diagnose and/or to guide treatment of a Mental Disorder.

32. Mental health treatment of pain, unless Medically Necessary.

33. Travel expenses, including room and board, even if the purpose is to obtain a Covered Service.

34. Holman is not liable for the lack of available services in the event of a major disaster, epidemic or pandemic, war, riot or other like circumstance beyond the control of Holman, which renders a Contracted Provider unable to provide services. However, Contracted Providers will provide or attempt to arrange for Covered Services according to their best judgment within the limitations of available facilities or personnel. If the Plan is unable to

provide services, it will refer Enrollees to the nearest hospital for Emergency Services and later provide reimbursement to the Enrollee for such Covered Services.

35. For Covered Services, Holman reserves the right to coordinate your care in a cost-effective and efficient manner.

36. Diagnostic procedures or testing for genetic disorders are not Covered Services.

37. Private Hospital rooms are not covered unless Medically Necessary and Prior Authorized by Holman.

ENROLLEE GRIEVANCE & APPEALS PROCESS

FILING GRIEVANCES. All Enrollees will have reasonable access to the filing of a complaint. Enrollee's shall have up to one hundred eighty (180) calendar days following any incident or action that is the subject of the Enrollee's dissatisfaction to file a grievance with Holman. Complaints may be reported to any Holman staff in person or by telephone by calling **(855) 345-1648**. Grievances may also be submitted in writing to The Holman Group, Attention: Deborah MacMurray, P.O. Box 8011, Canoga Park, CA 91309, or via The Holman Group's secure website at www.holmangroup.com or by email to Grievance@HolmanGroup.com. Grievance Complaint forms are also available from all Holman Contracted Providers promptly upon request or when indicated (via concerns voiced) by the Enrollee. Holman shall assure that there is no discrimination against an Enrollee (including but not limited to cancellation of the contract) on the grounds that the complainant filed a grievance.

Resolution of Grievances. Grievances will be directed to the Compliance Department. The Compliance Department will work together with the Enrollee to resolve the issue if possible. All grievances will be referred to the Grievance Committee unless the grievance is resolved within twenty-four (24) hours and/or the Enrollee declines the grievance process. Holman will mail the Enrollee a written acknowledgement of receipt of the grievance within five (5) calendar days (Acknowledgement Letter). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the Holman representative, telephone number and address of the Holman representative who may be contacted about the grievance. The Enrollee will be advised when the committee will be meeting regarding their grievance and include a brief description of their grievance in the letter. 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 why the grievance was denied and how the Enrollee may appeal the decision of the Grievance Committee. An Enrollee may submit a grievance to the Department of Managed Health Care for review, after completing Holman's grievance process or after having participated in Holman's grievance system for thirty (30) calendar days. Grievances may be reported to any Holman staff in person or by telephone by calling **(855) 345-1648**. Grievances may also be submitted in writing to The Holman Group, Attention: Deborah MacMurray, P.O. Box 8011, Canoga Park, CA 91309, or via The Holman Group's secure website at www.holmangroup.com or by email to Grievance@HolmanGroup.com.

Arbitration. If the Enrollee remains dissatisfied with the decision, the Enrollee may submit a request to Holman to submit the grievance to binding Arbitration before the American Arbitration Association. 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 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, 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 Association. The American Arbitration Association shall determine the approval or denial of a hardship application. A hardship application may be obtained by contacting the American Arbitration Association in Los Angeles at 213-383-6516, in San Diego at 619-239-3051 and in San Francisco at 415-981-3901.

If the Enrollee does not request arbitration within six (6) months from the date of the Grievance Resolution Notice, the decision shall be final and binding. However, if the Enrollee has legitimate health or other reasons that prevented 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 (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 Association, both the Enrollee and Holman agree to be bound by the rules of procedure and decision of the American Arbitration Association. Full discovery shall be permitted in preparation for arbitration pursuant to California Code of Civil Procedure, Section 1285.05.

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, Holman provides expedited review. When Holman has notice of a case requiring expedited review, Holman shall immediately inform the Enrollee verbally and in writing of their right to notify the Department of Managed Health Care 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 seventy-two (72) hours from receipt.

Treatment Denials. If a provider or Enrollee notifies Holman of a dissatisfaction regarding a treatment authorization denial, it will be directed to appropriate 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.

Treatment Denial Appeals. Enrollees may seek DMHC review after the grievance process with the Plan is completed or after thirty (30) days in the grievance process without resolution. 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 Medical Director for inpatient care or by the Holman doctorial 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.

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 seventy-two (72) hours of 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 your health plan, you should first telephone your health plan at (855) 345-1648 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

An Enrollee, or the agent acting on behalf of the Enrollee, may also request voluntary mediation with Holman prior to exercising the right to submit a grievance to the Department. The use of mediation services shall not preclude the right to submit a grievance to the Department upon completion of mediation. In order to initiate mediation, an Enrollee, or the agent acting on behalf of the Enrollee, and Holman shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The Department shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

Holman's Medical Necessity Philosophy. 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.

Holman's Public Policy Committee. Holman 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 Holman for behavioral health care services. In order to assure Enrollee participation in Plan policy, the Public Policy Committee shall consist of the following members: Holman President, Senior Vice President, Account Management staff, a current Holman provider and a minimum of current Enrollees who make up fifty-one percent (51%) of the committee. Any Enrollee interested in the Public Policy Committee may direct their request in writing to Holman, P.O. Box 8011, Canoga Park, CA 91309.

Language Assistance Program ("LAP") Services. Holman provides access to language assistance services, including verbal interpretation in the top fifteen (15) languages spoken by limited English-proficient individuals in California as determined by the Department of Health Care Services, or as

otherwise required by law, free of charge and in a timely manner, including but not limited to at the time of an appointment. These services can be accessed by contacting Holman at **(855) 345-1648**.

Additionally, Holman will translate all vital documents as defined by the DMHC, into the required threshold languages. For translation of non-vital documents, please contact Holman at **(855) 345-1648** or follow the directions in the notice at the bottom of the document you would like translated.

Additionally, Holman provides:

- Free aids and services to people with disabilities to help them communicate better, such as:

    - ✓ Qualified sign language interpreters
    - ✓ Written information in other formats (large print, braille, audio, accessible electronic formats, and other formats)

To access these services, please call Holman at **(855) 345-1648** or via TTY at (800)735-2929.

Non-Discrimination. Discrimination is against the law. The Holman Group complies with all applicable Federal and California non-discrimination requirements. The Holman Group does not discriminate, exclude people, or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, disability, or other protected class status. If you believe The Holman Group has failed to provide these services or discriminated in another way on the basis of ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, disability or other protected class status, you can file a grievance with The Holman Group at the contact information below.

The Holman Group provides:

- Free aids and services to people with disabilities to help them communicate better, such as:

    - ✓ Qualified sign language interpreters
    - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:

    - ✓ Qualified interpreters
    - ✓ Information written in other languages

If you need these services, contact The Holman Group twenty-four (24) hours per day/seven (7) days a week at **(855) 345-1648**. Or, if you cannot hear or speak well, please call (800) 735-2929.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability or sex by phone, in writing or electronically:

- By phone: Call (800) 368-1019. If you cannot speak or hear well, please call TTY/TDD (800)537-7697

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Service
  200 Independence Ave, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

- Electronically: visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

If you believe The Holman Group has failed to provide these services or discriminated on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, disability, or other protected status, you can file a grievance with The Holman Group. You can file a grievance by phone, in writing, in person, through our website, or electronically, as described below:

- By phone: Contact The Holman Group 24/7 by calling (855) 345-1648 at extension 221. Or, if you cannot hear or speak well, please call (800) 735-2929.

- In writing: Fill out a complaint form or write a letter and send it to:

  The Holman Group
  Attention: Deborah MacMurray
  P.O. Box 8011
  Canoga Park, CA 91309

- In person: Visit your provider's office and say you want to file a grievance.

- Electronically: Visit The Holman Group's website at www.holmangroup.com or email Grievance@HolmanGroup.com.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (855) 345-1648 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

An Enrollee, or the agent acting on behalf of the Enrollee, may also request voluntary mediation with the Plan prior to exercising the right to submit a grievance to the Department. The use of mediation services shall not preclude the right to submit a grievance to the Department upon completion of mediation. In order to initiate mediation, an Enrollee, or the agent acting on behalf of the Enrollee, and the Plan shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The Department shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph

Antifraud Policy and Procedures. Holman makes every effort to detect, investigate, and prosecute any incidents of fraud, waste, and abuse at any level within its behavioral health care services. Fraud hurts everyone through higher taxes to fund government health care plans and higher premiums for private health coverage. In order to ensure that our Enrollees do not have to pay for the high cost of fraud, we encourage you to report fake claim schemes and other suspected fraudulent activity. We are here to help you recognize and report any incidents or suspected incidents of fraud. If you notice that a claim submitted to Holman by your provider's office includes a charge for a therapy session or service 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 Holman at **(855) 345-1648.** Holman 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 to the extent legally possible. Furthermore, State and federal laws protect the confidentiality of your medical records. We will not release any medical information without lawful authorization.

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, Holman will deny the Enrollee any additional benefits under the Enrollee's Group Health Plan. 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.

Organ and Tissue Donation. Approximately 77,000 people in the U.S. are on the national waiting list for an organ. An average of fifteen (15) people die every day because not enough organs are available. Organ and tissue transplantation save lives. For example, about sixty (60) people receive life- enhancing organ transplants each day and about eighty-two percent (82%) of patients who receive a donated kidney are still alive five (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 web site at www.organdonor.gov or call: 1-888-ASK-HRSA ((888) 275-4772).

Timely Access to Care. The Holman Group appointment wait times are within the following timeframes; however, exceptions made be made in compliance with Department of Managed Health Care requirements:

Urgent Appointments	**Wait Time**
For services that do not need prior approval	48 hours
For services that do need prior approval	48 hours

Non-Urgent Appointments	Wait Time
Psychiatry services appointment	15 business days
Appointment with a mental health care provider (who is not a physician)	10 business days
Appointment for other services to diagnose or treat a health condition	15 business days

Telephone Wait Times:

- The Holman Group provides access twenty-four (24) hour per day, seven (7) days per week to qualified health professionals for triage or screening services by telephone at **(855) 345-1648** with wait times not to exceed thirty (30) minutes.

- During business hours, the waiting time for an Enrollee to speak by telephone to a Care Access Specialist knowledgeable and competent regarding the Enrollee's questions and concerns shall not exceed ten (10) minutes.

Language Assistance Services

Holman shall provide verbal interpreter services at the time of the appointment at no cost to the Enrollee. Please see the "Language Assistance Program" section above for more details on other language assistance services provided and how to request these services.

DEFINITION OF TERMS

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.

2. **Acute Psychiatric Hospital.** A licensed health facility with a medical staff that provides twenty-four (24)-hour inpatient care for behavioral health care patients.

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.

4. **Behavioral Health Treatment (BHT).** Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

(i) A qualified autism service provider.
(ii) A qualified autism service professional supervised by the qualified autism service provider.
(iii) A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

(i) Describes the patient's behavioral health impairments or developmental challenges that are to be treated.
(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
(iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.

5. **Benefits Schedule.** (Attached as Exhibits A and B, pages 35-40). The Benefits Schedule is a list of the various services covered under a health insurance plan, along with the associated fees including required deductibles and copayments.

6. **Contracted Provider.** A person licensed as a psychiatrist, psychologist, clinical social worker, marriage, family and child counselor, nurse, other licensed health care professional or qualified autism service provider, professional or paraprofessional within the relevant mental health scope of practice in behavioral health services, and who has contracted with Holman to deliver specified services to Holman Enrollees.

7. **Copayment/Cost-Sharing.** A 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 Association. Such fees may be a specific dollar amount or a percentage

of total fees, depending on the type of services provided. Can also be referred to as a deductible or co-insurance.

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 terms and conditions of the health care service plan contract. Upon Enrollee's request, Holman will disclose its processes including criteria and guidelines, for authorizing, modifying, or denying services

9. **Covered Services.** Behavioral health services and supplies provided by providers that are determined to be medically necessary and covered under a Group Plan Contract.

10. **Day Care Behavioral Health Services (as used in the context of Partial Hospitalization and Intensive Outpatient Services).** Includes the full range and scope of inpatient Behavioral Health Services, at both hospitals and facilities that are JCAHO or CARF accredited, except that the Enrollee continues to reside at home, but commutes to a treatment center up to seven days a week.

11. **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 contracted providers, in whole or in part due to a finding that the service is not medically necessary.

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

13. **Doctor of Osteopathic.** Medicine (D.O. is a fully trained licensed doctor who has attended graduated from a U.S. osteopathic medical school. A Doctor of Medicine (M.D.) has attend and graduated from conventional (allopathic) medical school.

14. **Domestic Partner.** Means an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

    1) Both partners are eighteen (18) years of age or older, except as provided in Section 297.1 of the California Family Code;
    2) The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
    3) The partners are (a) not currently married to someone else or a member of another domestic partnership, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
    4) Both partners are capable of consenting to the domestic partnership; and
    5) If required under the Association's written policy, both partners must file a Declaration of Domestic Partnership with the California Secretary of State, pursuant to the California Family Code.

The domestic partnership is deemed created on the date when both partners meet the above requirements.

15. **Eating Disorder.** For purposes of this manual, means the diseases of anorexia nervosa and bulimia nervosa and eating disorder not otherwise specified, as defined by the Diagnostic and Statistical Manual (DSM-5).

16. **Eligible Dependents.** Eligible Dependents include those described below that also meet applicable eligibility requirements: the spouse or Domestic Partner, or child, of an eligible Member, who is determined to be eligible and who is not independently covered as an eligible Member or Subscriber.

    1) A Dependent spouse is an individual who is legally married to the Subscriber, and who is not legally separated from the Subscriber.

    2) A Dependent Domestic Partner is an individual who meets the definition of Domestic Partner as defined in this EOC.

    3) A Dependent child is a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than twenty-six (26) years of age. A child does not include any children of a Dependent child (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

    4) If coverage for a Dependent child would be terminated because of the attainment of age twenty-six (26), and the Dependent child is disabled and incapable of self-sustaining employment, Benefits for such Dependent child will be continued upon the following conditions:

    a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;

    b. the Subscriber, spouse, or Domestic Partner must submit to Holman a Physician's written certification of disability within sixty (60) days from the date of the Association's or Holman's request; and

    c. thereafter, certification of continuing disability and dependency from a Physician must be submitted to Holman on the following schedule:

        i. within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and

        ii. annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage for any reason other than attained age.

17. **Eligible Member.** A Member of Association whose name appears on the list of eligible Members provided to Holman by Association pursuant to Association's obligations under the Group Plan Contract.

18. **Emergency Behavioral Health 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 a psychiatric

emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility. The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital or to an acute psychiatric hospital.

19. **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 applicable to this plan.**

20. **Member/Enrollee.** Individual who is a member of an Association, who has contracted with Holman for behavioral health care services.

21. **Association.** An organization that has contracted with Holman to provide behavioral health care services to its eligible members.

22. **Enrollee.** An eligible member (and/or such employee's/Enrollee's eligible dependents) of an Association who has contracted with Holman to provide behavioral health services to its Members/Enrollees. Member/Enrollee must meet Holman's eligibility requirements, enroll in the Association's Group Plan, and accept the financial responsibility for any copayments that may be incurred in treatment through the Group Plan.

23. **Evidence of Coverage and Disclosure Form (EOC).** Brochure issued to an Enrollee setting forth the coverage to which the Enrollee is entitled and describing the procedures in which Holman furnishes care.

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

25. **Fraud.** The deliberate submission of false information by a provider, Enrollee, plan employee, or other individual or entity, to gain an undeserved payment on a claim or other fraudulent acts.

26. **Good Cause.** A cause for cancellation of failure to renew which the Director has not found to be objectionable by regulation.

27. **Grace Period.** Means the period of at least thirty (30) consecutive days beginning the day the Notice of Start of Grace Period is dated. "Notice of Start of Grace Period'' means the notice sent by the Plan to the Enrollee, subscriber, or group contract holder that the Plan contract will be terminated unless the premium amount due is received by the Plan no later than the last day of the Grace Period.

28. **Group Plan Contract.** Agreement between an Association and Holman providing that Holman will provide behavioral health care services for the Association's eligible employees/Enrollees in exchange for Premium paid by the Association.

29. **Group Therapy Session.** Goal-oriented behavioral 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.

30. **Hospital.** A health care facility including any acute care hospital or acute psychiatric facility who has entered into a provider agreement with Holman to deliver a full range of mental health services on an inpatient treatment basis.

31. **Inpatient.** An Enrollee utilizing Holman's provided services in an inpatient behavioral health treatment center.

32. **Inpatient Behavioral Health Services.** Behavioral health services provided on a twenty-four (24)-hour basis at a Hospital including all procedures utilizing psychological principles and methods for the understanding, diagnosis, and treatment of Enrollees with mental disorders and alcohol, chemical dependence, substance abuse or mental health problems.

33. **Intensive Outpatient Services.** Intensive outpatient (IOP) services are non-residential, intensive, structured interventions consisting of counseling and education to improve the mental health, sexually harmful behavior, substance use disorder and /or eating disorder symptoms, up to seven (7) days a week.

34. **Language Assistance Program.** Holman 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 Language Assistance Program Regulations. Providers shall cooperate and comply, as applicable, with Holman's language assistance program; however, Holman shall maintain ongoing basis the language assistance program for Enrollees.

The Holman Group provides:

- Free aids and services to people with disabilities to help them communicate better, such as:

  ✓ Qualified sign language interpreters
  ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:

  ✓ Qualified interpreters
  ✓ Information written in other languages

35. **Letter of Agreement.** A contract entered by Holman and a licensed non-contracted provider to deliver services for a specific Enrollee.

36. **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.

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

38. **Medically Necessary/Medical Necessity.** Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient or physician, or other physician.

    For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors. For these purposes' "physician" means all credentialed eligible behavioral health providers which include, but are not limited to, clinicians, psychiatrists, nurse practitioners, social workers, and family therapists.

39. **Mental Disorder.** A behavioral or psychological syndrome that causes significant distress or disability, or a significantly increased risk of suffering death, pain, or an important loss of freedom. The syndrome is considered to be a manifestation of some behavioral, psychological, or biological dysfunction in the person (as recognized in the DSM -5, ICD-10).

40. **Mental Health Services.** Goal-oriented behavioral health services for the treatment of mental disorders including substance abuse.

41. **Non-Contracted Provider.** Any licensed provider not contracted with Holman to deliver services to Enrollees. Every effort will be made to ensure Enrollees are not subject to balance billing practices for services paid under the Holman Agreement. Enrollees may be liable to the non-contracted provider for the cost of services not covered or authorized by Holman. In the event Holman fails to pay non-contracted providers, the Enrollee may be liable to the non-contracted provider for the cost of services.

42. **Out-of-Pocket-Maximum.** The highest Cost-Sharing amount an individual or family is required to pay for designated Covered Services each year. Charges for services that are not covered, or charges in excess of the allowed charges or contracted rate, do not accrue to the calendar year Out-of-Pocket Maximum.

43. **Outpatient Behavioral Health Services.** Outpatient Behavioral Health Services are those Behavioral Health Services that are provided by a provider in his or her office or appropriate outpatient setting.

44. **Partial Hospitalization.** Partial hospitalization means an outpatient program specifically designed for the diagnosis or active treatment of a serious mental disorder when there is a reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse or full hospitalization. The Enrollee continues to reside at home, but commutes to a treatment center up to seven (7) days a week.

45. **Premium.** Predetermined monthly membership fee paid by an Association for coverage under the Group Plan Contract.

46. **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.

47. **Private Therapy Session.** A private therapy session consists of one Enrollee with a provider (rather than a Group Therapy Session) and includes:
    a. A 45 – 50-minute consultation as treatment needs dictate.
    b. A 45 – 50-minute psychological assessment and referral.
    c. The administering of standardized tests, including time involved in scoring and interpretation.
    d. A 30 – 45-minute unit of time to facilitate the admission of an Enrollee.

48. **Psychiatric Emergency Medical Condition.** A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: a) an immediate danger to himself or herself or to others; b) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

49. **Qualified Autism Service (QAS) Provider means either of the following:**
    e. A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.
    f. A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

50. **Qualified Autism Service Professional.** An individual who meets all of the following criteria:
    g. Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider; and
    b. Is supervised by a qualified autism service provider; and
    c. Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider; and
    d. Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program; and
    e. Has training and experience in providing services for pervasive developmental disorder or autism pursuant to applicable state law *(Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code);* and

f. Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

51. Qualified Autism Service Paraprofessional. An unlicensed and uncertified individual who meets all of the following criteria:

a. Is supervised by a qualified autism service provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice,
b. Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider;
c. Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; and
d. Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.
e. Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

52. Qualified Health Care Professional. A licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular condition(s) of the Enrollee.

53. Residential Treatment Center. A facility that is JCAHO or CARF accredited which provides a specific behavioral treatment program on a live-in basis pursuant to a written treatment plan approved and monitored by a practitioner, and which facility is also licensed, certified or approved as such by the appropriate state agency.

54. 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. Persists without full cure or worsens over an extended period of time;
2. Requires ongoing treatment to maintain remission or prevent deterioration.

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

56. Sub-Acute Care Facility. Any Licensed behavioral health, mental health or 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.

57. Treatment Plan. A written clinical presentation of the provider's diagnostic impressions and therapeutic intervention plans. The behavioral health treatment plan is submitted routinely to the Holman clinician for review as part of the concurrent review monitoring process.

58. Urgently Needed Behavioral Health Care Services. Medically Necessary behavioral health services required outside of the service area to prevent serious deterioration of an Enrollee's behavioral health resulting from sudden onset of illness or injury manifesting itself by acute behavioral health symptoms of sufficient severity, such that treatment cannot be delayed until the Enrollee returns to the service area.

59. **Utilization Management Committee (UMC).** A committee operating within Holman whose function is to assure both the quality and cost-effectiveness of treatments covered by Holman.

60. **Outpatient Visit.** An outpatient session with a provider conducted on an individual or group basis during which behavioral health services are delivered.

BENEFITS SCHEDULE
COVERAGE
EXHIBIT A

EFFECTIVE DATE AND PERIOD OF COVERAGE

January 1, 2025 to December 31, 2025

MEMBER ASSISTANCE PROGRAM

10 sessions, $0 copay per individual member, per incident, per benefit year (both family and household members are covered)

MENTAL AND BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT COVERED SERVICES COST-SHARING AND LIMITATIONS/EXCLUSIONS

(Please see the Definition of Terms section above for specific definitions)

1. COST-SHARING AND LIMITATIONS/EXCLUSIONS

a. Out-of-Pocket Maximum

Your medical and Mental and Behavioral Health and Substance Abuse Treatment coverage has an out-of-pocket maximum, or OOPM. This benefit limits how much you may have to pay out-of-pocket for your care per year and helps to protect your financial security. Deductibles, copayments, and coinsurance (Cost-Sharing) count toward your OOPM. The OOPM includes Cost-Sharing incurred for both Covered Mental and Behavioral Health and Substance Abuse Treatment Services and for the covered medical services received from your medical plan. Charges for services that are not covered or charges in excess of the allowed charges or contracted rate, do not count toward your calendar year OOPM.

Your total OOPM for both Covered Mental and Behavioral Health and Substance Abuse Treatment Services and for covered medical services is $500 per individual and $1,500 per family (combined with your medical plan OOPM). See your medical plan's EOC for more information.

b. Lifetime and Annual Dollar Limits and Pre-Existing Conditions

There are no lifetime or annual dollar limits except where permitted by law. All dollar limits, if any, are specified below. Holman has no pre-existing condition exclusions for any Enrollee.

c. Copayments, Co-insurance, and Other Charges by Benefit Type

i. Contracted (In-Network) Providers

Contracted Provider Covered Service	Applicable Cost-Share	Applicable Limits/Exclusions	Other Information
Deductible	**Not Applicable**	**Not Applicable**	**Not Applicable**
Out of Pocket Maximum	**$500 per individual/year $1,500 per family/year**	**Combined with Medical Plan**	**Mental Health/Substance Use visits/services count towards out of pocket maximum**
Emergency Room (Ambulance Covered by Medical Plan)	**No charge if admitted as inpatient. $25 copay for outpatient Emergency Room services**	**Same as Medical Plan**	**Same as Medical Plan**
Outpatient Therapy			
Individual Sessions	Copay: $0 per session	Unlimited Sessions	This benefit requires Prior Authorization from Holman. One individual session equals two group sessions.
Group Sessions	Copay: $0 per session	Unlimited Sessions	This benefit requires Prior Authorization from Holman. One individual session equals two group sessions.
Hospital Inpatient (Emergency Only)			
	Copay: $0 per day	Not covered unless the visit is a Psychiatric or Substance Use Medical Emergency or Holman has provided Authorization.	This benefit does <u>not</u> require Prior Authorization from Holman.
Residential Treatment (Emergency and Non-Emergency), Partial Day Treatment (Non-Emergency), Partial Hospitalization (Non-Emergency), and Intensive Outpatient (Non-Emergency)			

Contracted Provider Covered Service	Applicable Cost-Share	Applicable Limits/Exclusions	Other Information
Deductible	**Not Applicable**	**Not Applicable**	**Not Applicable**
Out of Pocket Maximum	**$500 per individual/year $1,500 per family/year**	**Combined with Medical Plan**	**Mental Health/Substance Use visits/services count towards out of pocket maximum**
Emergency Room (Ambulance Covered by Medical Plan)	**No charge if admitted as inpatient. $25 copay for outpatient Emergency Room services**	**Same as Medical Plan**	**Same as Medical Plan**
	Copay: $0 per day	*CARVE-OUT COVERAGE*: Unlimited to matching Inpatient benefit on medical plan.	This benefit requires Prior Authorization from Holman.

Additional Information and Exclusions/Limitations:

1. Preventive healthcare services are provided without Cost-Share. See your medical plan's EOC for a list of preventive services.

2. Some non-emergency services outside of California may be covered, depending on the circumstances. Please call (855) 345-1648 for more information.

3. See your medical plan EOC for more information regarding coverage, limitations/exclusions, and cost-sharing.

4. All services must be Medically Necessary in order to be covered. If a service is denied for lack of Medical Necessity, you may appeal the decision through the grievance and appeals process described above. Services received prior to or after your effective date of coverage with Holman are not Covered.

5. See the Exclusions and Limitations section in the EOC for more details.

ii. Non-Contracted (Out-of-Network) Providers

Non-Contracted Provider Covered Service	Applicable Cost-Share	Applicable Limits/Exclusions	Other Information
Outpatient Therapy	Not covered	Not covered	Not covered
Hospital Inpatient (Emergency)*	Copay: $0 per day	Not covered unless the visit is a Psychiatric or Substance Use Medical Emergency or Holman has provided Prior Authorization.	This benefit does not require Prior Authorization from Holman.
Residential Treatment (Non-Emergency), Partial Day Treatment, Partial Hospitalization, and Intensive Outpatient	Not covered	Not covered	Not covered

Additional Information and Exclusions/Limitations:

1. Assumption of Risk/Liability: Enrollees may be liable to a Non-Contracted Provider for the cost of services if services provided by the Non-Contracted Provider are not Prior Authorized by Holman (except for Emergency Behavioral Health Services and Care that do not require Prior Authorization).

2. In order to be reimbursed for Non-Contracted Provider Inpatient Hospital Emergency Behavioral Health Services and Care, the attending provider, Hospital, family member and/or Enrollee must notify Holman regarding the Non-Contracted Provider delivery of Emergency Behavioral Health Services and Care within 24 hours of seeking treatment or as soon as reasonably possible.

3. For Emergency Behavioral Health Services and Care only: Enrollees and Non-Contracted Providers must submit claims within one (1) year of the first date of service being rendered in order to be eligible for payment. Claims must outline all services provided on a daily basis. Claims may be mailed to: The Holman Group, P.O. Box 8011, Canoga Park, CA 91309.

6. See your medical plan EOC for more information regarding coverage, limitations/exclusions, and cost-sharing.

7. All services must be Medically Necessary in order to be covered. If a service is denied for lack of Medical Necessity, you may appeal the decision through the grievance and appeals process described above. Services received prior to or after your effective date of coverage with Holman are not Covered.

8. See the Exclusions and Limitations section in the EOC for more details.

Non-Contracted Provider Covered Service	Applicable Cost-Share	Applicable Limits/Exclusions	Other Information

d. Late Appointment Cancellation and No-Show Fees

a. Free Sessions

Enrollees forfeit one (1) session for failure to attend any free session except in the case where the Contracted Provider is notified of the cancellation 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.

b. Cost-Sharing Sessions

For Cost-Sharing Sessions, Enrollees will be charged the applicable Cost-Share or the sum of thirty-five dollars ($35.00) (whichever is greater), which must be paid directly to the Contracted Provider for any appointment made with a Contracted Provider that is not kept, except in the case where the Contracted Provider is notified of cancellation 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.

e. Non-Contracted Provider Fees

Holman uses RBRVS (professional) and DRGs (hospital) to calculate reimbursement for Non-Contracted Providers. Any disputes are to be negotiated directly with Holman. Every effort will be made to ensure that Enrollees of Holman are not subject to balance billing practices for Covered Services. RBRVS 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 at least annually and takes into consideration:

(i) the provider's training qualifications, and length of time in practice;
(ii) the nature of services provided;
(iii) the fees usually charged by the provider;
(iv) prevailing provider rates charged in the general geographic areas in which services were rendered;
(v) other aspects of the economics of the medical provider's practice that are relevant, and
(vi) any unusual circumstances in the case.

Notice to Enrollees. Federal law requires all Association benefit plan administrators to furnish each Enrollee 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 Association and Holman. The Group Plan Contract must be consulted to determine the exact provisions of the Group Plan Contract. Depending upon whom you contact, Holman or your Association will present a copy of the Group Plan Contract to you upon request.