COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

AGENDA

Executive Committee

June 4, 2025

12:00 PM

512 W. Aten Rd., Imperial, CA 92251

All supporting documentation is available for public review at https://chpiv.org

Committee Members	Representing	Present
Lee Hindman	LHA Chairperson – Joint Chambers of Commerce Nominee	
Yvonne Bell	LHA Vice-Chair & Finance Committee Vice-Chair – CEO, Innercare and CCIPA	
Dr. Carlos Ramirez	Finance Committee Chair – CEO/ Senior Consultant DCRC	
Dr. Unnati Sampat	LHA Commissioner – President of Imperial County Medical Society	
Dr. Allan Wu	LHA Commissioner – CMO of Innercare and President of CCIPA	

1. CALL TO ORDER *Lee Hindman, Chair*

A. Roll Call *Donna Ponce, Commission Clerk*

B. Approval of Agenda

1. Items to be pulled or added from the Information/Action/Closed Session Calendar
2. Approval of the order of the agenda

2. PUBLIC COMMENT *Lee Hindman, Chair*

Public Comment is limited to items NOT listed on the agenda. This is an opportunity for members of the public to address the Commission on any matter within the Commission's jurisdiction. Any action taken as a result of public comment shall be limited to the direction of staff. When addressing the Commission, state your name for the record prior to providing your comments. Please address the Commission as a whole, through the Chairperson. Individuals will be given three (3) minutes to address the board.

3. CONSENT AGENDA

All items appearing on the consent calendar are recommended for approval and will be acted upon by one motion, without discussion. Should any Commissioner or other person express their preference to consider an item separately, that item will be addressed at a time as determined by the Chair.

A. Approval of Minutes from 4/9/2025 and 5/7/2025……. *pg. 4-9*

B. Motion to recommend to the full commission the acceptance of monthly financial reports as reviewed and accepted by the Finance Committee

1. Executive Summary.....*pg. 10-11*
2. Enrollment Report ..... *pg. 12*
3. Statement of Revenues, Expenses, and Changes in Net Position..... *pg. 13*
4. Statement of Net Position (Assets) ..... *pg. 14*
5. Statement of Net Position (Liabilities & Net Position) ..... *pg. 15*
6. Summarized TNE Calculation ..... *pg. 16*
7. Cash Transaction Report ..... *pg. 17*

C. Motion to approve the annual Health Education Program and the Utilization Management Program as reviewed and accepted by the Provider Advisory and Quality Improvement Health & Equity Committees……. *pg. 18-116*

4. ACTION

A. Motion to adopt the CHPIV Governmental 457 (b) Plan……. *pg.117-205*

B. Review and Approval of Updates to the QIHEC Charter……. *pg.206-211*

5. INFORMATION

A. Health Services Report *(Dr. Gordon Arakawa, CMO and Jeanette Crenshaw, Executive Director of Health Services)* …….. *pg.212*

B. Financial Services Report *(David Wilson, CFO)*

C. Compliance Report *(Elysse Tarabola, CCO)*

D. Operations Report *(Julia Hutchins, COO)* …….. *pg. 213-218*

E. Human Resources Report *(Shannon Long, HR Consultant)* ……. *pg. 219*

F. CEO Report (*Larry Lewis, CEO)*

G. Other new or old business (*Lee Hindman, Chair)*

6. CLOSED SESSION

Pursuant to Welfare and Institutions Code § 14087.38 (n) Report Involving Trade Secret new product discussion (estimated date of disclosure, 10/2025)

7. RECONVENE OPEN SESSION

A. Report on actions taken in closed session.

8. ADJOURNMENT

Next meeting: July 9, 2025

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

MINUTES

Executive Committee
April 9, 2025
12:00 PM
512 W. Aten Rd., Imperial, CA 92251

All supporting documentation is available for public review at https://chpiv.org

Committee Members	Representing	Present
Lee Hindman	LHA Chairperson – Joint Chambers of Commerce Nominee	✓
Yvonne Bell	LHA Vice-Chair & Finance Committee Vice-Chair – CEO, Innercare	✓
Dr. Carlos Ramirez	Finance Committee Chair – CEO/ Senior Consultant DCRC	✓
Dr. Unnati Sampat	LHA Commissioner – Imperial Valley Medical Society	✓
Dr. Allan Wu	LHA Commissioner – Innercare	A

1. CALL TO ORDER *Lee Hindman, Chair*

Meeting was called to order at 12:00 p.m.

A. Roll Call *Donna Ponce, Commission Clerk*

Roll call taken and quorum confirmed. Attendance is as shown.

B. Approval of Agenda

1. Items to be pulled or added from the Information/Action/Closed Session Calendar
2. Approval of the order of the agenda

(Ramirez/Sampat) To approve the order of the agenda. Motion carried.

2. PUBLIC COMMENT *Lee Hindman, Chair*

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None.

3. CONSENT AGENDA

All items appearing on the consent calendar are recommended for approval and will be acted upon by one motion, without discussion. Should any Commissioner or other person express their preference to consider an item separately, that item will be addressed at a time as determined by the Chair.
(Ramirez/Sampat) To approve the consent agenda. Motion carried.

A. Approval of Minutes from 3/5/2025 ……*pg. 4-6*

B. Motion to recommend to the full commission the acceptance of monthly financial reports as reviewed and accepted by the Finance Committee…….. *pg. 7-13*

1. Executive Summary
2. Enrollment Report
3. Statement of Revenues, Expenses, and Changes in Net Position
4. Statement of Net Position (Assets)
5. Statement of Net Position (Liabilities & Net Position)
6. Summarized TNE Calculation
7. Cash Transaction Report

4. ACTION (No items)

5. INFORMATION

A. Health Services Report *(Dr. Gordon Arakawa, CMO and Jeanette Crenshaw, Executive Director of Health Services)* …… *pg.14*
Chief Medical Officer, Dr. Gordon Arakawa provided updates on Q1 2025 QIHEC. Executive Director of Health Services, Jeanette Crenshaw provided updates on NCQA Audit and Accreditation.

B. Financial Services Report *(David Wilson, CFO)* ……*pg. 7-13*
Financial Reports presented in CONSENT AGENDA, item 3B.

C. Compliance Report *(Elysse Tarabola, CCO)* ……*pg. 15-151*
Chief Compliance Officer, Elysse Tarabola provided updates on DHCS Medical Audit, DMHC Routine Survey, updated and new Policy & Procedures, and mandatory compliance training.

D. Operations Report *(Julia Hutchins, COO and Michelle S. Ortiz-Trujillo, Senior Manager of Marketing and Communications) ……. pg. 152-163*
Chief Operating Officer Julia Hutchins presented the Operations Report.
Senior Manager of Marketing & Communications Michelle Ortiz-Trujillo provided updates on member experience.

Vice-Chair Bell inquired about ongoing issues members are experiencing with ID cards.
Julia Hutchins responded that CHPIV will create specific plans once they get more information from Health Net.

Commissioner Sampat expressed concern regarding the availability of on-site assistance for members.
CEO Larry Lewis assured the Commission that efforts will be made to ensure that information about locally available services is clearly communicated to members.

E. Human Resources Report *(Shannon Long, HR Consultant) ……. pg. 164-165*
Human Resource Consultant, Shannon Long presented the Human Resources Report.

Chair Hindman inquired about the advantage of attending events and promoting CHPIV to current members.
CEO Larry Lewis responded that the primary purpose was to increase brand awareness.

F. CEO Report (*Larry Lewis, CEO)*
CEO, Larry Lewis provided updates on the following:
- Cancer Resource Center of the Desert closed business on March 28th
- DHCS and DMHC Audit
- Targeted Rate Increases
- Regulatory Budget Crunch

G. Other new or old business (*Lee Hindman, Chair)*
None.

6. CLOSED SESSION-None

Pursuant to Welfare and Institutions Code § 14087.38 (n) Report Involving Trade Secret new product discussion (estimated date of disclosure, 10/2025)

A. Conference Labor Negotiations *(Committee Members and CEO ONLY)*

B. Compliance

RECONVENE OPEN SESSION

A. Report on actions taken in closed session.

7. COMMISSIONER REMARKS (*Lee Hindman, Chair)*

Commissioner Sampat provided an update on recent changes to Medi-Cal. She noted that significant effort will be needed to inform members about these changes.

CEO Larry Lewis announced an upcoming reorganization of the LHA Commission and all committee agendas. He stated that each committee report will now include an Executive Summary. Additionally, commissioners will be issued laptops in the future to reduce printing costs.

A. Alternate Commissioner Member Assignment

Chair Hindman announced that he will be assigning alternates to each committee at the LHA Commission meeting.

8. ADJOURNMENT

Meeting was adjourned at 1:12 p.m.
Next meeting: May 7, 2025

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

MINUTES

Executive Committee
May 7, 2025
12:00 PM
512 W. Aten Rd., Imperial, CA 92251

All supporting documentation is available for public review at https://chpiv.org

Committee Members	Representing	Present
Lee Hindman	LHA Chairperson – Joint Chambers of Commerce Nominee	✓
Yvonne Bell	LHA Vice-Chair & Finance Committee Vice-Chair – CEO, Innercare and CCIPA	✓
Dr. Carlos Ramirez	Finance Committee Chair – CEO/ Senior Consultant DCRC	✓
Dr. Unnati Sampat	LHA Commissioner – President of Imperial County Medical Society	✓
Dr. Allan Wu	LHA Commissioner – CMO of Innercare and President of CCIPA	✓

1. CALL TO ORDER *Lee Hindman, Chair*

Meeting called to order at 12:00 p.m.

A. Roll Call *Donna Ponce, Commission Clerk*

Roll call taken and quorum confirmed. Attendance is as shown.

B. Approval of Agenda

1. Items to be pulled or added from the Information/Action/Closed Session Calendar
2. Approval of the order of the agenda

(Bell/Ramirez) To approve the order of the agenda. Motion carried.

2. PUBLIC COMMENT *Lee Hindman, Chair*

Public Comment is limited to items NOT listed on the agenda. This is an opportunity for members of the public to address the Commission on any matter within the Commission's jurisdiction. Any action taken as a result of public comment shall be limited to the direction of staff. When addressing the Commission, state your name for the record prior to providing your comments. Please address the Commission as a whole, through the Chairperson. Individuals will be given three (3) minutes to address the board.

None.

3. CLOSED SESSION

Pursuant to Welfare and Institutions Code § 14087.38 (n) Report Involving Trade Secret new product discussion (estimated date of disclosure, 10/2025)

Chair Hindman announces that the committee will enter into closed session.

4. RECONVENE OPEN SESSION

A. Report on actions taken in closed session.

Chair Hindman announces that the committee has reconvened into open session and reports that no action has been taken.

5. ADJOURNMENT

The meeting was adjourned at 1:00 p.m.

Next meeting: June 4, 2025

Financial Result

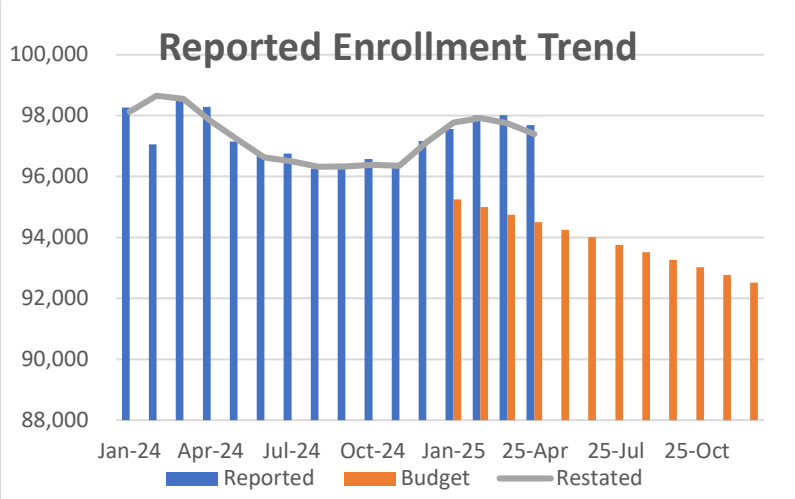
April 2025

Executive Summary

Membership

The reported Medi-Cal Membership saw a 0.3% decline in March, from 98K to 97.7K. While the membership erosion impacted most Category of Aids (COA), the most significant were observed in the Adult and Adult Expansion categories, which declined by 260, or 1.2%. Restated membership has also declined for 2 consecutive months and is on a similar slope as the budget.

Year-to-date membership is still above forecast by 11.8K member months.



Gross Margin

Revenue exceeded forecasts by $3.7M for the month, mainly due to retroactive rate adjustments of $3.7M. The distribution of at-risk revenue (97% sharing) and pass-throughs was consistent with the forecast. Volume adjustments accounted for $0.8M in favorable revenue.

Included in the April payment was a retroactive (2024) payment of $0.3M for the Student Behavioral Health Incentive, which is 100% pass-through to providers. This program was intended to provide additional avenues to address behavioral health in schools and school-affiliated settings, a measure included in Assembly Bill 133: Section 5961.3.

CHPIV membership is largely comprised of Satisfactory Immigration Status (SIS) members; only 6% of overall revenue for the month was related to UIS, or members with Unsatisfactory Immigration Status.

	Satisfactory Immigration Status (SIS)			Unsatisfactory Immigration Status (UIS)		
($,000)	Revenue	Enrollment	Rev % Total	Revenue	Membership	Rev % Total
Child	$ 4,514	34,242	17%	$ 74	784	0%
Adult	$ 3,614	14,655	14%	$ 333	1,084	1%
Adult Expansion	$ 6,775	23,981	26%	$ 585	1,816	2%
SPD	$ 4,095	4,514	15%	$ 266	224	1%
SPD Dual	$ 5,971	15,538	22%	$ 286	732	1%
LTC	$ 4	13	0%	$ 7	6	0%
LTC Dual	$ 36	94	0%	$ 0	1	0%
Total*	**$ 25,009**	**93,037**	**94%**	**$ 1,551**	**4,647**	**6%**

Gross margin was favorable by $103K for the month of April, and $0.6M YTD.

Administrative Expenses

Administrative expenses were favorable by $181K for the month of April. The main driver was the timing of consulting costs for the Medicare Bid (to be paid in subsequent months) and NCQA fees (paid in March). In addition to consulting, labor costs were also favorable primarily in the Compliance department due to delayed hiring.

Other

Investment income was favorable by $29K in April and $75K YTD.

On average, CHPIV's investable cash averaged $10.6M/month during 2024. In 2025, CHPIV's investable cash averaged $16.9M, a 59% increase. The budget assumed a modest 2% increase in investment income for 2025. These assumptions were based on moderate increases to investable cash, offset by downward pressure in interest rates.

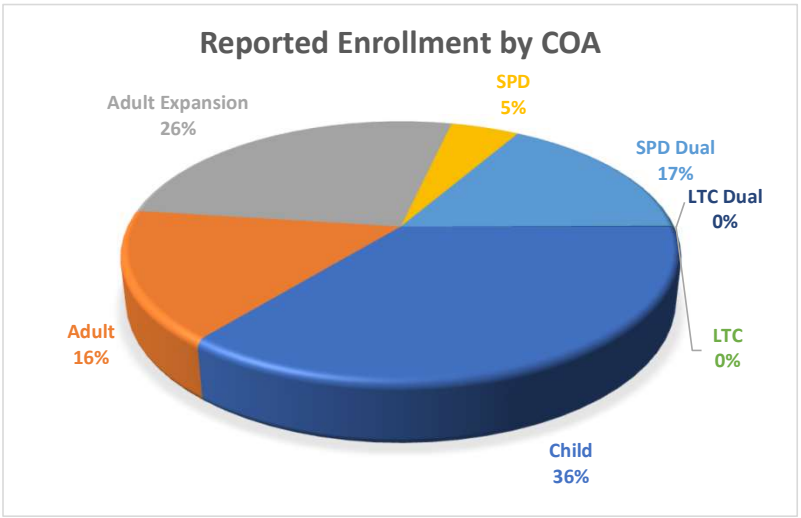
Tangible Net Equity (TNE)

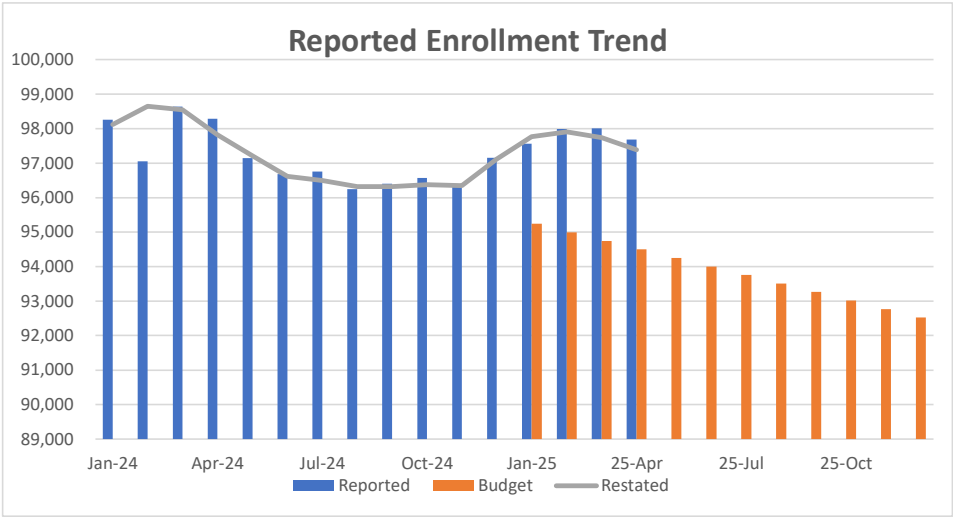
For the month of April, TNE was $21.8M, which is 453% of the required $4.8M. On a restated basis, TNE stands at 469% of the required levels.

Imperial County Local Health Authority
DBA Community Health Plan of Imperial Valley
Reported Enrollment
For April 2025

	2024				2025							
					April				April (YTD)			
							B/(W)				B/(W)	
Category of Aid (COA)*	Q1-24	Q2-24	Q3-24	Q4-24	Actual	Budget	#	%	Actual	Budget	#	%
Child	34,607	34,589	34,424	34,551	35,026	33,467	1,559	5%	140,518	134,756	5,762	4%
Adult	16,997	15,767	15,675	15,768	15,739	15,099	640	4%	63,159	60,867	2,292	4%
Adult Expansion	26,579	25,784	25,733	26,019	25,797	25,307	490	2%	103,715	101,585	2,130	2%
SPD	5,007	5,041	5,085	5,139	4,738	5,056	(318)	-6%	18,690	20,281	(1,591)	-8%
SPD Dual	14,433	14,760	15,007	15,288	16,270	15,438	832	5%	64,683	61,482	3,201	5%
LTC	12	15	19	22	19	29	(10)	-34%	84	107	(23)	-21%
LTC Dual	79	87	92	104	95	104	(9)	-9%	395	407	(12)	-3%
Total Medicaid	97,714	96,043	96,035	96,891	97,684	94,500	3,184	3%	391,244	379,485	11,759	3%
Monthly/Quarterly Change		*-1.7%*	*0.0%*	*0.9%*	*0.8%*	*-2.5%*						

** Source: DHCS 820 Remittance summary; includes retroactivity*





Revenue & Membership by COA

	Satisfactory Immigration Status (SIS)			Unsatisfactory Immigration Status (UIS)		
($,000)	Revenue	Enrollment	Rev % Total	Revenue	Membership	Rev % Total
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Total*	**$ 25,009**	**93,037**	**94%**	**$ 1,551**	**4,647**	**6%**

* Excludes Student Behavioral Health Incentive

Imperial County Local Health Authority
DBA Community Health Plan of Imperial Valley
Statement of Revenues, Expenses, and Changes in Net Position
For April 2025

	April			April (YTD)			
	Actual	Budget	Variance - B/(W)	Actual	Budget	Variance - B/(W)	Current Month Explanations
REVENUE							
Premium	$ 26,274,977	$ 22,836,205	**$ 3,438,771**	$ 110,299,296	$ 91,609,210	**$ 18,690,087**	Revenue was favorable by $3.7M largely due to the Rate/Mix of
Pass-Through	$ 582,893	$ 345,026	**$ 237,866**	$ 2,219,744	$ 1,384,237	**$ 835,507**	the population relative to the Budget. Prior period revenue was
HN Settlements	$ -	$ -	**$ -**	$ -	$ -	**$ -**	favorable by $0.5M; volume was favorable by $0.8M.
TOTAL REVENUE	**$ 26,857,869**	**$ 23,181,231**	**$ 3,676,638**	**$ 112,519,040**	**$ 92,993,447**	**$ 19,525,594**	
HEALTH CARE COSTS	$ 26,069,620	$ 22,496,145	**$ (3,573,475)**	$ 109,210,062	**$ 90,245,171**	**$ (18,964,891)**	
Gross Margin	**$ 788,249**	**$ 685,086**	**$ 103,163**	**$ 3,308,979**	**$ 2,748,276**	**$ 560,703**	
ADMINISTRATIVE EXPENSE							
Salaries & Wages	$ 285,544	$ 330,197	**$ 44,653**	$ 1,259,223	$ 1,282,174	**$ 22,952**	
Benefits Expense	$ 21,734	$ 26,041	**$ 4,307**	$ 101,429	$ 99,879	**$ (1,550)**	
Total Labor Costs	$ 307,278	$ 356,238	**$ 48,960**	$ 1,360,652	$ 1,382,053	**$ 21,402**	Salaries were favorable due to hiring delays in Compliance
Consulting, Legal, & Other Professional	$ 88,204	$ 195,026	**$ 106,822**	$ 414,896	$ 605,470	**$ 190,574**	Favorable consulting due to timing (Medicare Bid)
Advertising & Marketing	$ 1,392	$ 5,300	**$ 3,908**	$ 3,161	$ 11,963	**$ 8,802**	
Information Technology	$ 5,348	$ 3,721	**$ (1,626)**	$ 25,602	$ 18,486	**$ (7,116)**	
Membership and Subscriptions	$ 9,176	$ 9,180	**$ 4**	$ 37,616	$ 36,720	**$ (896)**	
Regulatory Fees	$ 28,500	$ 27,597	**$ (903)**	$ 113,800	$ 112,851	**$ (950)**	
Travel	$ 3,228	$ 11,558	**$ 8,331**	$ 16,265	$ 42,158	**$ 25,894**	Delayed travel from Compliance
Meals & Entertainment	$ 938	$ 500	**$ (438)**	$ 3,808	$ 2,300	**$ (1,508)**	
Insurance and Banking	$ 5,340	$ 7,509	**$ 2,169**	$ 20,171	$ 30,035	**$ 9,864**	
Occupancy & Facility	$ 3,764	$ 4,717	**$ 953**	$ 16,219	$ 18,868	**$ 2,650**	
Office Expense	$ 2,550	$ 5,360	**$ 2,810**	$ 14,802	$ 26,539	**$ 11,737**	
Other Admin	$ 1,947	$ 12,361	**$ 10,414**	$ 6,610	$ 18,917	**$ 12,307**	Favorable due to timing of property tax liability
Total Administrative Expense	**$ 457,663**	**$ 639,067**	**$ 181,404**	**$ 2,033,601**	**$ 2,306,361**	**$ 272,760**	
Non-Operating Income							
Dividend, Interest & Investment Income	$ 116,088	$ 87,391	**$ 28,697**	$ 424,470	$ 349,565	**$ 74,906**	Favorable investment income due a combination of higher
Rental Income	$ 1,494	$ 1,450	**$ 44**	$ 5,974	$ 5,800	**$ 174**	portfolio balance and rate of return on investments.
Total Non-Operating Income	$ 117,581	$ 88,841	**$ 28,740**	$ 430,444	$ 355,365	**$ 75,080**	
Depreciation & Amortization	$ 10,656	$ 11,000	**$ 344**	$ 42,622	$ 44,000	**$ 1,378**	
Change in Net Position	**$ 437,512**	**$ 123,860**	**$ 313,652**	**$ 1,663,200**	**$ 753,281**	**$ 909,920**	
Key Metrics							
Enrollment	97,684	94,500	**3,184**	391,244	379,485	**11,759**	
Revenue PMPM	$274.95	$245.30	**$29.64**	$287.59	$245.05	**$42.54**	
MLR	97.07%	97.0%	**(2) bps**	97.1%	97.0%	**(1) bps**	
Admin Ratio	1.7%	2.7%	**105 bps**	1.8%	2.5%	**67 bps**	
Net Income PMPM	$4.48	$1.31	**$3.17**	$4.25	$1.99	**$2.27**	
Net Income %	1.6%	0.5%	**109 bps**	1.5%	0.8%	**67 bps**	

Imperial County Local Health Authority dba
Community Health Plan of Imperial Valley
Statement of Net Position
As of April 30, 2025

ASSETS

Current Assets	Mar 2025	Apr 2025	Change
Cash and Investments			
Chase - Checking	$ 200,159	$ 200,000	$ (159)
Chase - Money Market	2,217,675	3,106,052	888,377
JPMorgan Securities	14,815,977	14,945,031	129,054
First Foundation Bank	288,046	159,216	(128,830)
Receivables			
Accounts Receivable	160	-	(160)
Dividend Receivable	11,564	13,282	1,718
Interest Receivable	104,339	102,806	(1,533)
Capitation Receivable	27,875,775	26,274,977	(1,600,798)
Pass-Through Receivable	340,864	284,709	(56,155)
Pass-Through Receivable - Other	6,594,899	3,268	(6,591,631)
Other Current Assets			
Prepaid Expenses	63,404	392,203	328,799
Total Current Assets	**52,512,862**	**45,481,545**	**(7,031,318)**
Noncurrent Assets			
Restricted Deposit			
First Foundation Bank - Restricted	300,000	300,000	-
Capital Assets			
Buildings - Net	2,931,862	2,923,314	(8,548)
Computer Equipment / Software - Net	72,438	71,019	(1,418)
Improvements - Net	44,770	44,362	(408)
Operating ROU Asset (Copier) - Net	5,630	5,349	(281)
Total Noncurrent Assets	**3,354,699**	**3,344,044**	**(10,655)**
Total Assets	**$ 55,867,562**	**$ 48,825,589**	**$ (7,041,973)**

Imperial County Local Health Authority dba
Community Health Plan of Imperial Valley
Statement of Net Position
As of April 30, 2025

	Mar 2025	Apr 2025	Change
LIABILITIES			
CURRENT LIABILITIES			
Payables			
Accounts Payable	$ 32,098	$ 431,936	$ 399,838
Capitation Payable	27,039,501	25,486,727	(1,552,774)
Pass-Through Payable	340,864	582,893	242,028
Pass-Through Payable - Other	6,594,899	3,268	(6,591,631)
Credit Card Payable	5,922	8,749	2,827
Other Current Liabilities			
Short Term Lease Liability - Copier	3,437	3,453	16
Bonus Accrual	203,269	221,484	18,216
Salaries Accrual	156,376	160,856	4,480
Vacation Accrual	156,766	154,577	(2,190)
Total Current Liabilities	**34,533,132**	**27,053,943**	**(7,479,190)**
NON-CURRENT LIABILITIES			
Long Term Lease Liability - Copier	2,398	2,103	(295)
Total Noncurrent Liabilities	**2,398**	**2,103**	**(295)**
Total Liabilities	**34,535,531**	**27,056,046**	**(7,479,485)**
NET POSITION			
Net investment in Capital Assets	3,054,700	3,044,044	(10,656)
Restricted by Legislative Authority	300,000	300,000	-
Unrestricted	16,751,642	16,762,298	10,656
Net Revenue	1,225,689	1,663,201	437,512
Total Net Position	**21,332,031**	**21,769,543**	**437,512**
Total Liabilities and Net Position	**$ 55,867,562**	**$ 48,825,589**	**$ (7,041,973)**

Imperial County Local Health Authority dba
Community Health Plan of Imperial Valley
Summarized Tangible Net Equity Calculation
As of April 2025

	Net Equity	$ 21,769,543
	Add: Subordinated Debt and Accrued Subordinated Interest	$ 0
	Less: Report 1, Column B, Line 27 including: Unsecured Receivables from officers, directors, and affiliates; Intangibles	$ 0
	Tangible Net Equity (TNE)	$ 21,769,543
	Required Tangible Net Equity *	$ 4,808,979
	TNE Excess (Deficiency)	$ 16,960,563

	Full Service Plan		* Calculated Required Tangible Net Equity	
		1		
A.	Minimum TNE Requirement	$ 1,000,000	$ 330,897,889	- Q1
			$ 330,897,889	- Annualized
B.	REVENUES:			
			$ 150,000,000	
	2% of the first $150 million of		x 2%	
	annualized premium revenues	$ 3,000,000	$ 3,000,000	
	(lines 1, 2, 4, 5, 7, 9 from Income Statement)			
	Plus			
			$ 180,897,889	
	1% of annualized premium revenues		x 1%	
	in excess of $150 million	$ 1,808,979	$ 1,808,979	
	Total	$ 4,808,979	$ 4,808,979	- Required TNE

Community Health Plan of Imperial Valley
April 2025 Cash Transactions

Date	Account	Vendor	Memo/Description	Amount
Chase Checking				
04/07/2025	Chase Checking	JPMorgan Chase	Dividend Income - Mar 2025	$ 11,564.01
04/07/2025	Chase Checking	JPMorgan Chase	Service Charges Investment Sweep - April 2025	-751.45
04/10/2025	Chase Checking	Wakely Consulting Group	Chase Bill Pay - Invoice #211734-0000004	-23,132.50
04/10/2025	Chase Checking	First Unum Life Insurance Company	Chase Bill Pay - Service Period: 04/01 -04/30	-576.20
04/10/2025	Chase Checking	AM Copiers Inc.	Chase Bill Pay - Invoice #IN7137	-477.57
04/10/2025	Chase Checking	Republic Services	Chase Bill Pay - Invoice #0467-001741600	-146.82
04/10/2025	Chase Checking	Stericycle, Inc.	Chase Bill Pay - Invoice #8010223493	-111.27
04/10/2025	Chase Checking	Shannon Long	Chase Bill Pay - Invoice #10	-6,000.00
04/10/2025	Chase Checking	Technology Depo	Chase Bill Pay - Invoice #15110, 15109, 15045 &15161	-1,163.11
04/10/2025	Chase Checking	I.V. Termite & Pest Control	Chase Bill Pay - Invoice #348678	-120.00
04/10/2025	Chase Checking	KY Cakes	Chase Bill Pay - Invoice #11	-110.00
04/10/2025	Chase Checking	Moss Adams	Chase Bill Pay - Invoice #102729696	-5,250.00
04/10/2025	Chase Checking	Law Office of William S. Smerdon	Chase Bill Pay - Invoice #2733	-1,485.00
04/10/2025	Chase Checking	Quench USA	Chase Bill Pay - Invoice #INV08724645	-129.30
04/10/2025	Chase Checking	City of Imperial	Chase Bill Pay - Invoice #1426298	-134.87
04/10/2025	Chase Checking	Brawley Rotary Club	Chase Bill Pay - March Statement	-205.00
04/14/2025	Chase Checking	Mid Atlantic Trust Company	Mid Atlantic Payment 03/15/2025 - 03/28/2025	-6,659.36
04/21/2025	Chase Checking	Department of Health Care Services	DHCS (March 2025 Revenue)	27,407,110.71
04/21/2025	Chase Checking	Department of Health Care Services	DHCS (March 2025 Revenue)	6,591,344.96
04/21/2025	Chase Checking	Department of Health Care Services	DHCS (March 2025 Revenue)	707,175.32
04/21/2025	Chase Checking	Department of Health Care Services	DHCS (March 2025 Revenue)	59,213.81
04/21/2025	Chase Checking	Department of Health Care Services	DHCS (March 2025 Revenue)	44,998.32
04/21/2025	Chase Checking	Department of Health Care Services	DHCS (March 2025 Revenue)	1,695.09
04/21/2025	Chase Checking	State Compensation Insurance Fund	State Compensation Insurance Payment	-1,424.41
04/21/2025	Chase Checking	JPMorgan Chase	Chase Credit Card Payment	-13,326.11
04/21/2025	Chase Checking	Commissioner Distribution	Payroll - Check: Commissioner C. R	-300.00
04/21/2025	Chase Checking	Commissioner Distribution	Payroll - Check: Commissioner B. A.	-100.00
04/21/2025	Chase Checking	Commissioner Distribution	Payroll - Check: Commissioner L. H.	-300.00
04/21/2025	Chase Checking	Commissioner Distribution	Payroll - Check: Commissioner M. W.	-100.00
04/21/2025	Chase Checking	Commissioner Distribution	Payroll - Check: Commissioner R. K.	-100.00
04/21/2025	Chase Checking	Commissioner Distribution	Payroll - Check: Commissioner P. V.	-100.00
04/24/2025	Chase Checking	Hechos Y Opinion El Lechugon	Chase Bill Pay - Invoice #Y025-03-2142 & Y025-03-2141	-415.67
04/24/2025	Chase Checking	Oracle America, Inc.	Chase Bill Pay - Invoice #2142006 & 2142010	-13,569.99
04/24/2025	Chase Checking	Sparkling Clean	Chase Bill Pay - Invoice April2025	-900.00
04/24/2025	Chase Checking	Brawley Chamber of Commerce	Chase Bill Pay - Invoice #24252	-75.00
04/24/2025	Chase Checking	I.V. Termite & Pest Control	Chase Bill Pay - Invoice #34973 & #349737	-270.00
04/24/2025	Chase Checking	Commission Distribution	Payroll - Check: Commissioner A. W	-100.00
04/24/2025	Chase Checking	Economic Group Pension Services	Chase Bill Pay - Invoice #224610	-562.00
04/24/2025	Chase Checking	Health Management Associates, Inc.	Chase Bill Pay - Invoice #206100-0000022 & #210806-000008	-2,897.50
04/24/2025	Chase Checking	Great America Financial Services	Chase Bill Pay - Invoice #39023325	-306.01
04/24/2025	Chase Checking	ADT Security Services	Chase Bill Pay - Invoice 04/21/25 - 05/28/25	-139.84
04/30/2025	Chase Checking	Health Net	Rental Income - April 2025	1,493.50
04/30/2025	Chase Checking	Mid Atlantic Trust Company	Payroll Date: 04/28/25 Retirement Contribution:	-3,171.63
04/30/2025	Chase Checking	KY Cakes	Return Check for Keyla Frayre	50.00
04/30/2025	Chase Checking	Department of Health Care Services	Receipt - DHCS (April 2025 Revenue)	298,183.34
First Foundation Bank				
04/15/2025	FFB Payroll	First Foundation Bank	3/24/25 - FFB Credit Card Overpayment	159.90
04/15/2025	FFB Payroll	Rippling	4/02/25 - People Center Bill	-67.07
04/15/2025	FFB Payroll	Rippling	4/01/25 -Employee Reimbursement - D. Arakawa, J. Hutchins & S. Castro	-1,704.09
04/15/2025	FFB Payroll	State of Colorado	4/08/25 - Colorado Family and Medical Leave Insurance Program	-588.93
04/15/2025	FFB Payroll	Blue Shield Insurance	4/08/25 - Blue Shield Insurance	-21,031.51
04/15/2025	FFB Payroll	Rippling	4/01/25 -Employee Reimbursement - J. Espinoza	-12.00
04/15/2025	FFB Payroll	Rippling	4/03/25 - Payroll Date: 04/04/25 Accrued Taxes	-49,623.87
04/15/2025	FFB Payroll	Rippling	4/03/25 - Payroll Date: 04/04/25 Accrued Wages	-77,108.01
04/15/2025	FFB Payroll	First Foundation Bank	4/03/25 - Wire Fee	-10.00
04/30/2025	FFB Payroll	Rippling	04/17/25 - Employee Reimbursement - J. Perez	-13.58
04/30/2025	FFB Payroll	Rippling	04/17/25 - Payroll Date: 04/18/25 Accrued Taxes	-49,500.81
04/30/2025	FFB Payroll	Rippling	04/17/25 - Payroll Date: 04/18/25 Accrued Wages	-77,086.80
04/30/2025	FFB Payroll	Rippling	04/18/25 - Employee Reimbursement - D. Wilson & J. Hutchins	-1,242.85
04/30/2025	FFB Payroll	Rippling	04/22/25 - Employee Reimbursement - E. Tarabola	-316.24
04/30/2025	FFB Payroll	Rippling	04/29/25 - Employee Reimbursement - E. Tarabola	-259.20
04/30/2025	FFB Payroll	Rippling	1st Quarter 2025 Adjustment Employer Taxes	-424.92
J.P. Morgan Securities				
04/30/2025	Chase Bond Portfolio	JPMorgan Chase	Bank Fee - March 2025 (Portfolio)	-20.00
04/30/2025	Chase Bond Portfolio	Health Net	March Health Net Payment	-33,975,264.97
04/30/2025	Chase Bond Portfolio	JPMorgan Chase	Accrued Investment Income - March 2025	$ 104,338.89

2025

Health Net Community Solutions, Inc.
and
Community Health Plan of Imperial Valley

Utilization Management Program Description

TABLE OF CONTENTS

Section 1

Introduction and Background

Introduction and Background

Introduction

The Community Health Plan of Imperial Valley (CHPIV) Utilization Management (UM) Program Description summarizes the policies, processes and standards that govern UM programs. Detailed policies and procedures support this document to assist in program implementation and to provide a step-by-step procedural instruction for Utilization Management staff in the program execution of both delegated and non-delegated models.

The Program is structured to assure that medical decisions are made by qualified health professionals, using written criteria based on sound clinical evidence, without undue influence or concerns for the plan's fiscal performance.

The Utilization Management Program Description summarizes the utilization management policies and procedures, the utilization management process, and the use of utilization management standards.

The Utilization Management Program delegates specified aspects of medical management to utilization management committees established by each Participating Provider Group (PPG).

The level of delegation is based on Health Net's pre-contractual and annual evaluation of the PPG's performance of utilization management functions.

Background

CHPIV is responsible for ensuring that utilization management services are available for all its Members. Health Net Community Solutions, Inc. (Health Net) is contracted with CHPIV to provide and arrange for utilization management services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation, a publicly traded company. Health Net is a registered service mark of Health Net, LLC.

Provider Network

Health Net operates largely as a delegated group network model for the delivery of health care. Services are provided under the following types of contractual arrangements:

- Practitioners and providers contracted with Health Net's network of Participating Provider Groups (PPGs)
- Practitioners and providers contracted directly with Health Net.

Health Net contracts with many multi-specialty Participating Provider Groups (PPGs) throughout California who, in turn, contract with or employ primary care and specialty

care practitioners. Health Net maintains contracts with a full range of providers including acute care hospitals, home health care, infusion therapy, dialysis, durable medical equipment, outpatient surgery, radiology/imaging, skilled nursing, custodial care/long term care, intermediate care facility, rehabilitation, laboratory services and hospices.

Health Net delegates to its PPGs and selected providers specific credentialing, utilization management, and claims functions, where appropriate.

Confidentiality

Health Net has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of Members, employees, providers and the Company, and to ensure the appropriate and legitimate use of information. Health Net contracts require that practitioners and providers maintain the confidentiality of Member information and records. Information or copies of records may be released only to authorized individuals as permitted by state and federal law.

Prior to participation in the UM Program, participants are educated regarding confidentiality requirements. All protected Member information is maintained in a secure fashion in accordance with federal and state law. All staff charged with handling any confidential Member information are regularly updated in privacy and confidentiality policies and procedures. Full access to HIPAA (Health Insurance Portability and Accountability Act) policies and procedures as well as self-paced, online resources, is available to all HN staff via the corporate intranet websites, including “Archer” and “Centene University”.

The Health Net Privacy Office is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, use and disclosure of medical information.

Information Systems and Analysis

Health Net’s Information Systems consist of various integrated subsystem databases, which support UM. The major sources of data utilized for UM activities are obtained from the following subsystems:

- Membership
- Benefits
- Provider
- Claims
- Billing
- Capitation
- Encounters
- Credentialing
- Population Health and Clinical Operations (PHCO)
- Customer Service
- Appeals and Grievance

Analytical resources are directly available from the following Health Net departments: Information Systems, Quality Improvement and Pharmacy Operations. Other analytical support resources include Actuary, Finance, Provider Network Management, Medical Advisory Council, Customer Service and Claims. Additional sources of information include Member and provider feedback.

Section 2

Purpose

About Health Net

Health Net provides access to high-quality health care, innovative programs and a wide range of health solutions that help families and individuals get well, stay well, and be well.

Mission

Transforming the health of the communities we serve, one person at a time.

Values

Accountability • Courage • Curiosity • Trust • Service

Health Net Community Solutions UM Purpose

The purpose of Health Net's Utilization Management Program is to design and implement programs that facilitate the highest level of the Member's health care outcomes, and to monitor and evaluate the effectiveness of these programs in compliance with the Community Health Plan of Imperial Valley Medi-Cal Contract, and State and Federal regulations.

The Utilization Management Program identifies and manages Members who are currently accessing health care services.

The purpose of the UM Program is to:

- Assist in the coordination of medically necessary medical and behavioral health care services provided to Members, as indicated by clinical criteria
- Provide a mechanism to address issues related to access and timeliness of care
- Initiate documentation to support investigation of potential quality of care concerns
- Identify and resolve issues leading to excessive resource utilization and inefficient delivery of health care services
- Identify and resolve issues that result in either underutilization or over utilization of services
- Assess the impact of cost containment activities on the quality of care provided
- Promote the role of the primary care physician in the management of patient care
- Identify opportunities to improve the health of Members through integration and coordination within PHCO and external Public Health Programs
- Optimize the Member's health benefits by linking and coordinating services with appropriate county and state sponsored programs

Goals and Objectives

The Program has the following specific objectives:

- Ensure consistent application of all UM functions for Members
- Review and assess health care services for quality, medical necessity and appropriate levels of care
- Identify and evaluate actual and potential quality issues during the review process and refer to the appropriate quality management personnel
- Evaluate the need for care management and discharge planning in coordination with the hospital and primary care providers (PCPs)
- Aggregate utilization data to identify favorable and aberrant practice patterns, and recommend the necessary changes that will improve program effectiveness and efficiency
- Maintain compliance with regulatory timeliness
- Prepare and implement improvement plans for identified problem areas
- Provide a mechanism for maintaining confidentiality of Member and provider
- Coordinate Utilization Management, Care Management and Quality Management activities to provide a continuous quality improvement process
- Work collaboratively with Delegation Oversight to determine delegation status for UM activities
- Evaluate the UM Program regularly to adapt to changes in the health care environment
- Collaborate with county Public Health-Linked Programs to ensure effective care delivery
- Provide equitable access to care by addressing health disparities such as structural racism and social risk, social determinates of health (SDoH), and specific community needs
- Recommend and implement strategies to eliminate health disparities and improve individual and community health outcomes
- Ensure full compliance with mental health parity requirements, applicable laws, regulations, and accreditation standards, fostering equitable access to mental health services.

Section 3

Description of Program

Description of Program

Utilization and Care Management

The Health Net Utilization Management Program is designed to ensure all Members receive quality, medically necessary health care services, delivered at the appropriate level of care in a timely, effective manner by Health Net's delegated and non-delegated providers. The Utilization Management Program operates under the clinical supervision of the Health Net, LLC Chief Medical Officer who please a key role in the implementation of the Program.

Scope of Utilization Management

The scope of Health Net's non-delegated Utilization Management activities encompasses timely, direct referrals, prior authorization, concurrent review, discharge planning, care management and care coordination with Public Health-Linked Programs. Health Net conducts all utilization management activities in accordance with CA Health and Safety Code §1367.01.

Through Health Net's Provider Oversight Process, Participating Provider Groups (PPGs) may be delegated the responsibility for the aforementioned UM activities.

Health Net has developed, implemented, and continually enhances updates the UM Program to ensure effective processes are in place to review and approve the provision of medically necessary covered services. The plan is staffed with qualified professionals who are dedicated to its implementation and oversight.

The plan ensures the separation of medical decision making from fiscal and administrative management, safeguarding against undue influence on medical decisions. The plan ensures covered services are provided as set forth in the California Code of Regulations (CCR), Title 22, Chapter 3, Article 4, beginning with Section 51301 and CCR, Title 28 section 1300.67.3 (a) (1) and California Health and Safety code section 1367 (g), except as excluded under the terms of the Plan's Medi-Cal contract and as referenced in applicable Medi-Cal Managed Care Division (MMCD) All Plan Letters. Additionally, Health Net's Utilization Management Programs adhere to all applicable requirements set forth by CMS, DHCS, DMHC and Managed Risk Medical Insurance Board (MRMIB) for Utilization Management and Care Coordination activities.

The Program is conducted in accordance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d) and 42 CFR 438.900 et seq.

Utilization Management policies and procedures are available to Members and providers upon request.

Health Net Utilization Management nurses provide decision support, Member advocacy, identification and recommendation of alternative plans of care, identification and use of alternative funding and coordination with community resources to support the Member's plan of care.

Direct Referrals/Self-Referrals

For delegated PPGs, Health Net allows the medical groups to establish policies and procedures for direct referrals. Health Net has established direct referrals for non-delegated practitioners when the Member's Primary Care Physician refers the Member directly to a specialist for consultation and evaluation without prior authorization or prior review by the Health Net Medical Director. Direct referrals are designed to enhance the Member's ability to directly access specialists.

Preauthorization/Prior Authorization

Health Net requires delegated PPGs to develop and maintain programs, policies and procedures that meet Health Net's established standards. Health Net Utilization Management staff is responsible for making pre-service decisions for request types that are not delegated.

Pre-service decisions include both the initial determination of requests for urgent and non-urgent services and requests for continuity of care services. Pre-service decisions are required for:

- Elective inpatient admissions,
- Services out of the CalViva Health service area, if not an emergency or urgent care
- Selected ambulatory surgery,
- Long-term care or skilled nursing services at a nursing facility (including adult and pediatric Subacute Care Facilities contracted with the Department of Health Care Services Subacute Care Unit) or intermediate care facilities (including Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), ICF/DD-Nursing (ICF/DD-N))
- Durable medical equipment,
- Select specialized treatments such as home IV infusion
- Select diagnostic and radiology procedures.
- Medical transportation services when it is not an emergency

The purpose of obtaining a pre-service decision is to prospectively evaluate proposed services to determine if they are:

- medically necessary,
- covered by the Member's benefit plan,
- the most current and appropriate medical or behavioral health interventions utilizing clinical criteria for determining medical and behavioral health appropriateness that are based on sound clinical evidence,
- provided by a contracted practitioner or provider, where appropriate or possible, and
- provided in the most appropriate setting.

Health Net, along with its delegated PPGs, does not require prior authorization for the following services or others as required:

- emergency services,
- minor consent services
- adult sensitive care services
    - family planning and birth control including sterilization for adults 21 and older,
    - pregnancy testing and counseling and other pregnancy related services
    - HIV/AIDS prevention and testing
    - sexually transmitted infections prevention testing
    - sexual assault care
    - outpatient abortion services
- preventive services from a participating provider
- basic prenatal care with a participating network obstetrician
- specialist referral (initial referral to participating specialist)
- urgently needed services when the Member is outside their county
- certified nurse midwife and obstetrical/gynecological (OB/GYN) services from a participating provider
- MOA 638 Indian Health Service facilities
- biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer (FDA approved)
- COVID-19 diagnostic and screening testing
- services that are rendered under the Children and Youth Behavioral Health Initiative fee schedule
- initial mental health and substance use disorder assessments
- adult preventive immunizations from a participating physician or other provider
- second opinion from a participating physician or other provider
- Comprehensive Perinatal Services Program (CPSP) services

Health Net has established a tracking system to monitor referrals requiring prior authorization. Health Net's authorization tracking system includes authorized, denied, deferred and/or modified authorizations. The process of authorization tracking includes monitoring of timeliness.

Inpatient Facility Concurrent Review

Concurrent Review (CCR) is an assessment that determines medical necessity or appropriateness of services as they are rendered, i.e., an assessment of the need for continued inpatient care for patients or when Member is stabilized following an emergency admission and requires pos-stabilization care. Any review for continued benefit coverage and provision of an approved ongoing course of treatment over a period of time or number of treatments. Concurrent review is a member-centric process that includes medical necessity review, discharge and transitional care planning and coordination of care.

A goal of CCR is to support the Member and Member's health care team to optimize health outcomes when the Member experiences a health status change. This is done in collaboration with the PPG, Member and the Interdisciplinary Care Team to:

1) Ensure services are accessed timely,
2) Educate the Member's health care team about the Member's benefit structure and resources,

3) Facilitate expeditious authorization of services when appropriate, and
4) Facilitate referrals to relevant Member resources, such as the behavioral health team, care management, and community resources or carve our programs such as California Children's Services program, the Local Education Agency (LEA) program, or the County Mental Health Program etc.

The CCR nurse supports a smooth transition from the acute care setting or skilled nursing facility (SNF) to the next level of care or community service. This is achieved by bridging the inpatient to outpatient process, facilitating health care services and supporting Member care management programs.
Health Net nurses, Medical Directors, and delegated partners conduct telephonic concurrent review of patients admitted to hospitals, rehabilitation units, custodial care/long term care, intermediate care facility, or skilled nursing facilities. Health Net may also monitor and provide concurrent review support for selected delegated partners, which retain a UM delegated status.

The inpatient review process occurs within one business day from the day of hospital admission or notification of admission and continues throughout the patient's hospital stay.

For post-stabilization care, the Plan make a decision within 30 minutes whether to approve or disapprove an admission or transfer the Member (if they are currently in a non-participating facility). If the response to approve or disapprove the request is not given within 30 minutes, the post-stabilization care request is authorized.

The review process includes application of standardized nationally recognized criteria for medical appropriateness review, evaluation of levels of care, discharge planning, and transitional care management including assessment of medically appropriate alternatives to inpatient care.

The concurrent review nurses utilize nationally recognized criteria, including InterQual® criteria, Hayes, and Health Net's Medical Hierarchy Policy to assess the appropriateness of the admission, level of care, and length of stay. The determination of medical appropriateness includes consideration of the individual patient's needs, as well as the capacity of the local delivery system such as in remote sections of the state. Board-certified physician specialists are utilized in making medical determinations as needed.

Health Net non-clinical staff support pre-service and concurrent review with data entry, receipt and documentation of notifications, and receipt and attachment of clinical content.

Requests that do not meet guidelines or criteria for approval are referred to a Health Net Medical Director for second level case review. During the concurrent review process, nurses assess the Member specific care management and disease/ chronic condition management needs and refer such cases to Care Management for evaluation. Concurrent Review Nurses collaborate with Care Managers on all Members identified in active care management.

CCR goals include supporting the Member and Member's health care team to optimize health outcomes in the event the Member experiences a health status change. This is done through work and advocacy with the PPG, Member and/or the interdisciplinary care team to:

1) ensure services are accessed timely,
2) educate to the Member's health care team on the Member's benefit structure and resources,
3) facilitate expeditious authorization of services when appropriate, and
4) facilitate referrals to appropriate Member resources, such as the behavioral health team, care management, and community resources.

The CCRN supports a smooth transition from the acute care setting or SNF to the next level of care/community. This is achieved by bridging the inpatient to outpatient process through facilitation of health care services and Member care management support programs.

Discharge Planning

Health Net and/or its delegated partners conduct and facilitate discharge planning to promote continuity and coordination of care in collaboration with the practitioner, the Member, and the Member's family to ensure a timely and safe discharge. Discharge planning begins pre-service or on the first day of the Member's admission, whenever possible. The concurrent review nurse is responsible for facilitating, coordinating and authorizing referrals for discharge needs, including but not limited to:

- home health care,
- durable medical equipment and/or
- transfers to a lower level of care (e.g., skilled nursing facility, custodial care/long term care, intermediate care facility or acute rehabilitation).

HN Concurrent Review nurses identify potential care management cases and refer them to Care Management and other outpatient programs for post discharge evaluation and/or services.

The criteria used for evaluating and guiding timely discharge planning include nationally recognized criteria such as InterQual®, Hayes, and Health Net's Medical Hierarchy policy. Discharge planning is part of the Utilization/Care Management Program and includes, but is not limited to:

- Assessment of continuity of care, including the identification of Community Supports and Complex Care Management needs
- Assessment of Member's support system to determine necessary services and support needs

- Development of a discharge plan of care based on short-term medical and psychosocial needs
- Coordination and implementation of services requested in the plan of care

Post Service/Retrospective Review

Delegated PPGs conduct post service or retrospective review activities in alignment with Health Net standards. Health Net performs this activity for non-delegated providers.

Health Net and its delegated partners perform post-service or retrospective review of medical records when services rendered have not been pre-authorized. Any services failing to meet criteria are forwarded to Health Net and delegated partners' Medical Directors for final determination and payment adjudication recommendations. The purpose of post-service review is to evaluate the request for authorization against documented medical record evidence that the Member received the services and that services meet the criteria for medical necessity. Determinations are processed after obtaining all necessary information required to review the request.

Second Opinion

A Member, the Member's authorized representative or a provider may request a second opinion for medical, surgical or behavioral health conditions. PCPs usually refer their assigned Members who request a second opinion to a participating physician within their medical group. If a Member requests a second opinion about specialty care from a participating specialist physician who practices outside of the Member's PCP's medical group, the request will be forwarded to Health Net Utilization Management for review. Health Net does not routinely require prior authorization for second opinion services given that the second opinion is provided within or outside the Member's Participating Physicians Group or Network, but within the Health Net Network. However, in the event the Member's plan requires prior authorization of such services, the determination will be made in a timely manner consistent with state specific mandates. The organization provides for second opinion from an in-network provider or arranges for the Member to obtain a second opinion outside the network. There is no cost to the Member for second opinion either in network, or authorized out of network.

Members may obtain a second opinion from a qualified health care professional. If an appropriate professional is not available in-network, Health Net will arrange for the Member to obtain a second opinion out-of-network at no cost to the Member.

Management of Information Systems

Health Net utilizes automated documentation systems to enter, view, and audit medical management information, ensuring accurate and streamlined data management.

Provider Participation

Health Net contracts with primary and multi-specialty group practices, individual providers, hospitals and ancillary service providers to deliver high-quality, cost-effective

medical services to Members and their dependents. The foundation for accessing appropriate health care services is the selection of a Primary Care Provider (PCP) and establishment of a relationship with that provider. PCPs include: Internists, Family Practitioners, General Practitioners, Pediatricians, Nurse Practitioners and Women's Health Care Providers (WHCP).

Access/Availability to Health Care Services

Health Net conducts ongoing review of the Health Plan's provider network to ensure the availability and access to all needed levels of care. The review includes an analysis of the scope of the network physicians, including Primary Care Physicians, specialists, facilities and ancillary services in relationship to Members' needs. Site and medical record reviews are also conducted to ensure that access to care and services, and the confidentiality of Member records are met. When gaps or unmet needs are identified, targeted recruitment efforts are initiated to enhance the network and ensure comprehensive coverage for all Members.

Coordination with Quality Improvement Programs

The Health Net Utilization Management Department and the delegated PPGs identify and refer sentinel events and potential quality of care/service issues to the Health Net Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization/care management activities. Quality of care, quality of service and Member complaints are monitored and analyzed by the Peer Review Investigations Team (PRIT) to determine whether further actions are needed, including but not limited to: review by the Peer Review Committee (PRC). Corrective actions, as appropriate, may be imposed by the PRC and are designed and monitored to continually improve Member care and service.

Coordination with Internal Programs

For delegated providers, Health Net requires regular, standardized UM reports. For non-delegated providers and with the aforementioned submitted material, Health Net's Utilization Management Department:

- Identifies and refers sentinel events and potential quality of care/service issues to the Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization management and care management activities.
- Identifies and refers appropriate Members for Public Health, Long Term Services and Supports (LTSS), waiver programs and "Carve Out" services, e.g., CCS, Members with Serious Mental Health, School Based Services (LEA carve out) and Regional Centers.
- Identifies and refers appropriate Members for Health Education Services, including tobacco cessation and obesity prevention programs.
- Identifies and refers appropriate Members for Cultural and Linguistic Services, including Members needing translation of documents or interpreter service for office visits.
- Offers disease/chronic condition management Programs for all Members who meet enrollment criteria for specific gateway conditions regardless of a Member's

delegated provider group status. Disease/chronic condition management activities are provided in coordination with Health Net and/or PPG UM activities.

Behavioral Health Care Services

The behavioral health team administers the Medi-Cal Non-specialty Mental Health Services (NSMHS)carved into the Managed Care Plans.

The behavioral health team provides early and periodic screening, diagnosis and treatment services for Members ages 0 to 20. These services include medically necessary Behavioral Health Treatment (BHT) such as Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention regardless of diagnosis in compliance with APL 22-006 and APL 23-010.

The behavioral health team will manage specified mental health benefits to adults, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Members with moderate to severe distress or impairment as well as Members seeking other services not provided by the behavioral health team, will be referred to the County Specialty MHP.

The behavioral health team's utilization management decisions are based on nonprofit professional association criteria and guidelines such as Council of Autism Service Provider (CASP) and American Psychological Association. The behavioral health team's evidence-based criteria guidelines include the American Psychiatric Association Practice Guidelines, the American Psychological Association and the Council of Autism Service Providers.

Federal law requires a health insurance issuer to establish parity in the terms and conditions applicable to medical and mental health benefits, as specified. All covered mental health and substance use disorder benefits must be provided in compliance with the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26 and Section 10112.27). The behavioral health team and Health Net do not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq., to timelines and processes. Community Health Plan of Imperial Valley shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the Plan's provider network. Community Health Plan of Imperial Valley will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. Community Health Plan of Imperial Valley will cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

Utilization management techniques are considered an NQTL under the definitions of the federal rules. The behavioral health team may not impose an NQTL with respect to

mental health or substance use disorder benefits in any classification unless the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used in applying the limitation with respect to medical/surgical benefits in the classification, timelines and processes in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.,

Further, the underlying processes, strategies, and evidentiary standards, considered by the behavioral health team and Health Net when determining if a NQTL will apply to a service, will be conducted in an equitable manner across all medical/surgical and mental health and substance use disorder benefits. Factors considered in the determination process are supported by internal data reports, internal medical records review, credible medical literature, peer-reviewed journals and other scientific evidence.

The core objective of utilization management at the behavioral health team is to manage available behavioral health care benefits to achieve the best possible clinical outcomes for Members with the most efficient use of resources. The focus of the process is on care, not costs. To that end, the behavioral health team has developed a clinical infrastructure to support its system as follows:

- Treatment is in the least restrictive setting at which safe and effective treatment can be rendered; this helps to preserve and foster as much independence, freedom and autonomy for the patient as possible.
- Multidisciplinary cooperation incorporates the unique perspectives and skills of behavioral health disciplines.
- A systems orientation views the patient as a Member of his/her family, job, social system, and community network, all of which may be involved in the treatment plan.
- The behavioral health team utilization management program provides clinical review for services requiring authorization. The bulk of the outpatient services provided by the behavioral health team do not require authorization. All behavioral health team staff making utilization management decisions are appropriately licensed Care Managers and Medical Directors.

The behavioral health team coordinates Continuity of Care (COC) for Members following existing COC provisions under California state law.

Pharmacy

The corporate pharmacy division of Health Net, Centene Pharmacy Services, administers and manages the medical drug benefit for Health Net's Medi-Cal membership. Programs are developed to ensure appropriate utilization of medications: Medical Benefit Drug Prior Authorization, Education programs for physicians and Members, and Pharmaceutical Safety.

A Pharmacy and Therapeutics Committee, consisting of community practicing Physicians, Health Net Pharmacists and Medical Directors review and approve all

medications administered under the medical benefit, as well as approve all criteria guiding prior authorization decisions.

The Health Net Pharmacy Advisory Committee (PAC) is responsible for oversight and communication about Health Net's pharmaceutical program. The quarterly Committee advises on medical and pharmacy drug benefit services to ensure they are being managed effectively and efficiently, while ensuring quality care is provided to the health plan membership. Membership includes CalViva Health Chief Medical Officer, Health Net's Medical Directors or his/her designees, Centene Pharmacy Services California Pharmacy team, physicians and pharmacists, and other areas that may be impacted by pharmacy operations.

Continuity and Coordination of Care

Several mechanisms are implemented to monitor, evaluate and facilitate continuity and coordination of care among its Members served by delegated and non-delegated providers. These activities include:

- The administration of care management for complex cases requires the use of multiple health services. Care Managers act as facilitators, resource finders and coordinators who are responsible for bridging communication and problem solving with practitioners. In addition, they assist in facilitating Members and their families to implement a smooth and coordinated plan of care.

- Implementation of specific population-based, chronic condition management or disease-focused interventions such as interventions for frequent emergency room utilization, high risk perinatal care management, asthma or diabetes.

- Coordinating transition of care for Members who are currently under care and are new to the Plan or are changing providers: All Medi-Cal Plan Members with pre-existing provider relationships have the right to request continuity of care in accordance with state law, and the Plan Medi-Cal contract, with some exceptions.

- Members/Providers who make a continuity of care request to the Plan are given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible Members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another Managed Care Plan (MCP). The Plan will automatically provide 12 months of Continuity of Care for a Member in a skilled nursing facility or for the provision of completing covered services by a terminated or out of network provider.

- The continuity of care process is facilitated by licensed nurses based on Member or provider request and meeting of continuity of care conditions per DHCS and DMHC regulatory requirements.

- Care Managers are patient advocates and assist Members to ensure that they receive timely and uninterrupted medical care during the transition process.

Primary Care Physician responsibility:

The Primary Care Physician is responsible for the management and coordination of a Member's complete medical care including initial and primary care, initiating specialty referral, and maintaining continuity of care to include coordination of specialty care, emergency services, and inpatient services.

Health Net supports the medical home model of primary care, and provides significant support to the primary care provider practices. This support ensures the primary care doctor has all care plans, and health risk assessments created by Health Net's programs or by one of the County or carve out programs such as CCS on file. Health Net requires that primary care providers provide in-office access to patients at a minimum of 20 hours per week and have availability for urgent and emergent Member needs 24 hours a day, 7 days a week.

As an additional aid to the primary care provider, Health Net provides a nurse advice line 24 hours a day, 7 days a week. Health Net strives to continually meet the access and availability standards through our network relationships, Member and provider education and triage services.

Over and Under Utilization

Health Net requires all providers are required to submit claim/encounter data for all services rendered. Multiple methodologies are utilized to monitor under and over utilization, including referral timeliness, provider appeals, denials, Member appeals and grievances. The types of methods include:

- Annual evaluation of network-wide PPGs Medi-Cal utilization management programs
- Over/Under utilization identified through Member complaints tracking
- Focused audits
- Analysis of medical group-specific inpatient utilization, ER usage, and pharmacy data
- Evaluation of individual direct contract physician practice patterns

Health Net's Utilization Management Department and the behavioral health team facilitates the delivery of health care services and monitors the impact of the UM Program to detect and correct potential under- and over-utilization through these comprehensive monitoring efforts:

- Establishing thresholds for compliance and measures compliance to guidelines
- Monitoring utilization data collected to detect potential under- and over-utilization.
- Routinely analyzing all data collected to detect under- or over-utilization.
- Analysis occurs on a semi-annual basis at minimum to ensure appropriate service and to identify opportunities for improvement.
- Tracks performance against established goals
- Implementing appropriate interventions when problems are identified.
- Educates and addresses variances from agreed upon clinical criteria
- Monitors provider prescribing patterns including medication utilization metrics
- Conducts provider outreach programs to modify performance

- Measuring whether the interventions have been effective and implementing strategies to achieve appropriate utilization.

Examples of data types and metrics identified that are relevant to provision of medically necessary services for all Members. Examples:

- For outpatient services, units/1000.
- For outpatient services, unique patients/1000.
- For outpatient services, units/unique patient.
- Report likely driving factors for the above patterns of utilization.
- Population Health Management key performance indicator metrics
- Dental anesthesia data is analyzed to identify and mitigate issues that may adversely impact the provision of medically necessary services received by Members.
- In addition, suspected fraud, waste and abuse of medical services is monitored and reported.
- Provider prescribing patterns including medication utilization metrics

Health Net completes the Quality Management education process with its contracted providers through local interaction with the Medical Directors at the Joint Operations Meetings, the Delegation Oversight team, the Provider Manual and Provider Updates, corrective action plans, the peer review and credentialing process.

Utilization Decision Criteria

Health Net's Utilization Management Program use the following guidelines to make medical necessity decisions (listed in order of significance) on a case-by-case basis, based on the information provided on the Member's health status:

1. State law/guidelines such as
    a. Title 22 CCR,
    b. Title 17 CCR,
    c. Medi-Cal Managed Care Division (MMCD) All Plan, Policy and Duals Plan Letters
    d. California Department of Health Care Services (CA DHCS) Medi-Cal Provider Manuals.
    e. State definition of medical necessity: Title 22 CCR Section 51303(a) and expanded for those under the age of 21 in W & I Code Section 14132 (v)
    f. SB855 for mental health and substance abuse (MH/SA) the most recent versions of treatment criteria developed by nonprofit professional agencies
2. Plan-specific clinical policy
    a. includes custom content within InterQual® and
    b. other vendor specific criteria;
3. Centene clinical policy
    a. Includes Centene customized clinical policies within InterQual®;
4. Nationally recognized decision support tools
    a. when no specific Plan, or Centene clinical policy exists, tools such as InterQual® Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are applied;
5. Additional considerations (if no guidance from A-D), when available:

a) Peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations;
b) Recognized United States professional standards of safety and effectiveness for diagnosis, care, or treatment;
c) Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
d) Medical association publications;
e) Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
f) Published expert opinions (e.g., Up-To-Date);
g) Opinion of health professionals in the area of specialty involved;
h) Opinion of attending provider in case at hand.

Benefit determinations are based on the following:
A. Medi-Cal Benefit Plan Contract
B. Applicable State and Federal Requirements
C. Member Handbook/Evidence of Coverage
D. Preferred Drug List (PDL)

Conflict Resolution:
- When Medi-Cal (state Medicaid) coverage provisions conflict with the Plan or Centene specific clinical policies, Medi-Cal coverage provisions take precedence.
- Refer to the Medi-Cal manual for applicable coverage provisions.

Transparency and Accessibility:
- Clinical policies, benefit provision, guideline, protocol or criteria are available upon request, in compliance with Federal and State regulations.

Separation of Medical Decisions from Fiscal and Administrative Management

In Health Net's UM Program, medical decisions made by Plan or PPG medical directors will not be unduly influenced by fiscal or administrative management. In order to accomplish this, Health Net affirms that:

Medical Necessity and Appropriateness:
- Utilization management decisions are based on medical necessity and medical appropriateness

No Compensation or Incentives for Denial:
- Health Net does not provide compensation to physicians or nurse reviewers for denials of service requests
- Health Net does not offer incentives to encourage denials of coverage or service and
- Special attention is paid to the risk of under-utilization

Policy Transparency:
- Health Net and its delegates distribute a statement to all practitioners, providers, and employees describing Health Net's policies and restrictions on financial incentives

Decision Making integrity:

- Utilization management decision making is based only on appropriateness of care and service and existence of coverage
- Health Net delegates are prohibited from rewarding practitioners or other individuals conducting utilization review for issuing denials of coverage or service

Independent Oversight:

- Health Net Medi-Cal Medical Directors and the Health Net Community Solutions CMO/VP Medical Director do not report to Health Net's Chief Financial Officer or its Marketing Director

Consistency of Application of Utilization Decision Criteria

Health Net ensures the consistent application of utilization decision criteria through structured processes and evaluations involving both Health Net staff and delegated PPG's such as:

- **Weekly Regional Utilization Management (UM) Rounds** – Use of Rounds facilitates interdisciplinary collaboration to enhance consistent decision-making, optimize patient outcomes, and improve resource management.
- **PPG Collaboration –** PPG management issues are referred to the Provider Oversight Department for resolution.
- **Real-Time Feedback from Leadership** – Continuous guidance and support from medical leadership are provided to reinforce standardized decision-making practices.
- **Ongoing UM Training** – Mandatory training sessions led by the Learning and Development team for all clinical review staff, both new and existing including training that focuses on:
  - Clinical Criteria Hierarchy and its application
  - Identification and utilization of available criteria sources

Inter-Rater Reliability (IRR) Review Process:

New hire and annually, IRR testing are conducted on all licensed UM clinicians with the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews. New UM staff are required to successfully complete IRR testing prior to being released from training oversight.

Staff are required to test on the Medical Necessity Criteria products applicable to their role. All staff must score 90% or greater for any new hire and annual IRR test. If a staff Member scores < 90% for any subset the staff must complete remediation and successfully retest within 30 days of completing remediation. Documented Coaching will be initiated by the People Leader for any staff with a final score of less than 90% for any IRR test. Documented Coaching may include but is not limited to the following: precepting of staff, retraining of the staff or auditing five (5) cases in production, for any IRR Product(s) not passed. In the event the New Hire and Annual IRR test(s) are not completed within the designated testing period, a failure of all applicable IRR tests is applied, and Documented Coaching is initiated by the People Leader.

IRR results are reported annually at the HNCS Quality Improvement Health Equity Committee Meeting and subsequently to CHPIV.

Health Net evaluates delegated PPGs' consistency of application of decision criteria through:

- Annual PPG oversight, includes a file review of denial files using Health Net Provider Delegation Oversight Interactive Tool (DOIT)
- Annual PPG oversight audit with specific inter-rater reliability verification
- Routine reporting of UM activities on a quarterly basis
- Health Net's Medical Directors evaluate and review all Member appeals for PPG denied services for appropriate use of medical necessity criteria. Health Net's Medical Directors provide feedback as needed to PPG Medical Directors through letters or telephonic communication as needed

Standards of Timeliness of UM Decision Making

Health Net maintains strict adherence to established time frames for UM decision making to ensure that Members receive timely care. These time frames are designed to minimize disruptions in the provision of healthcare services and are based on the urgency of the clinical situation.

Key Points on Timeliness of Decision Making:

- Turnaround Time (TAT) Standards
  - The TAT standards for decisions making regarding medical necessity and authorization requests are guided by current DHCS, DMHC, and State regulatory guidelines.
  - The most stringent of these guidelines are applied to ensure compliance and consistency.
- Timeliness Communication
  - All decisions regarding authorization or medical necessity are communicated to both the Member and the provider within the required regulatory timeframes.
  - The communication method and timeframe are determined by DHCS, DMHC, and State regulations, whichever set of guidelines has the most stringent requirement
- Delegated Provider's Compliance
  - Health Net's delegated providers are informed of the decision timeliness standards as outlined in the Provider Operations Manual.

By maintaining these standards and monitoring compliance, Health Net ensures that healthcare decisions are made promptly and in accordance with regulatory requirements, ensuring Members receive timely care and services.

Denials

A Member case is referred to the appropriate clinical practitioner, i.e., a Medical Director or a Pharmacist when UM medical necessity criteria are not met. The clinical reviewer may request additional pertinent clinical information, may contact the requesting practitioner by telephone to discuss the case, or may consult with a board-certified medical specialist before making the determination of medical necessity.

For any Major Organ Transplant (MOT) denial consideration, the HNCS Chief Medical Officer (CMO), or a delegated HNCS senior Medical Director reviews the request and determines the appropriateness of a denial.

The appropriate clinical practitioner makes UM medical necessity denial decisions, clearly stating the reason for the denial. Members, practitioners and providers receive written notification of all denials in accordance with all regulatory guidelines.

Denial notification letters include the reason for the denial, criteria utilized in the decision, benefit coverage when appropriate, the appeal mechanism, the right to a Fair Hearing, DHCS and DMHC required specific language, and alternative treatment recommendations when applicable. Health Net has implemented translation of denial letters into “threshold languages” in collaboration with Health Industry Collaboration Effort (HICE).

The rationale contained in denial letters includes a summary denial reason/rationale that is easily understandable for the Member. In addition, a detailed denial reason/rationale is included which outlines benefit provisions, guidelines, protocols or similar criteria on which the denial is based.

Should the requesting practitioner wish to discuss the case related to the denial decision, they are provided with the contact telephone number to schedule a conversation with the Medical Director or Pharmacist who issued the denial and the Medical Director contact information is available on the provider portal website.

Appeals

A licensed physician reviews all Member medical necessity appeals.

Community Health Plan of Imperial Valley has established procedures and turnaround times for standard and expedited appeals including the right to an external review.

Under the Administrative Service Agreement with CHPIV, Health Net is responsible for appeals for their Members. Health Net receives the appeal, collects the clinical information, prepares the case and initial review and determinations are made by a Health Net Medical Director.

Health Net maintains well-publicized and readily available appeal mechanisms for Members and practitioners for medical necessity denials issued by CHPIV or its delegates.

Each denial letter that is sent to the Member includes the Member’s right to appeal and/or fair hearing, independent medical review, and instructions on how to initiate a routine or expedited appeal.

The member’s right of appeal is communicated to the practitioners in the Provider Operations Manual and to the Members in the copies of denial notifications sent. The Member Handbook also delineates the appeals process describing how to initiate an appeal verbally by contacting the Member Services Department by phone. The Member

Services representative then forwards requests for Member appeals to the Appeals and Grievances Department.

Practitioner appeals are forwarded to the Provider Services Department. Appeals initiated by practitioners on behalf of a Member for medical services that have not yet been provided are considered to be Member appeals.

Health Net Medical Directors will utilize board certified physician consultants from appropriate specialty areas, including behavioral health, to determine medical necessity when specialty specific input is deemed necessary.

Evaluation of Medical Technology and Procedures

Health Net has a formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies to ensure Members have equitable access to safe and effective care and for inclusion in applicable benefit packages.

The Change Healthcare/Optum InterQual® criteria, the Hayes, Inc. Medical Technology Directory and other evidence-based resources are used as primary sources. This includes:

- Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and the National Comprehensive Cancer Network® (NCCN®) Guidelines.
- Medical association publications, government-funded, or independent entities that assess and report on clinical care decisions and technology, including Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, and National Institute for Health and Care Excellence (NICE).

In addition to Health Net's primary sources, Centene's Corporate Clinical Policy Department and Clinical Policy Committee in conjunction with Health Net of California's Medical Advisory Council are responsible for the evaluation of new technology that may be sought by Members. A critical appraisal of the current published medical literature from peer-reviewed publications is undertaken to assist in the evaluation of medical technology.

Satisfaction with the Utilization Management Process

At least annually, Health Net surveys Members and practitioners regarding their satisfaction with utilization management procedures and addresses identified areas and sources of dissatisfaction with interventions implemented by Health Net or delegated PPGs. Reports are presented at the HNCS QIHEC where recommendations for corrective action are made. Member and practitioner satisfaction information is reported at the HNCS QIHEC Committee.

Communication Services

The Plan, the behavioral health team and the delegated partners provide access to Utilization Management staff for Members and practitioners seeking information about the utilization management process and the authorization of care. Staff within Health Net, the behavioral health team and delegated partners are available at least eight hours a day during normal business days to receive and respond to inbound inquiries. In addition, Medi-Cal Members have 24/7 access to the nurse advice line. Inbound and outbound communication regarding utilization management issues is accomplished through the following:

- Toll-free Member/provider services telephone number/fax or email.
- Voicemail message capability during and after business hours; message retrieval for messages left after hours performed the next business day.
- Free translation and interpreter services for CHPIV Members upon request

The Plan will notify contracting health care providers, as well as Members and potential enrollees upon request of all services that require prior authorization, concurrent authorization or post-service authorization and ensure that all contracting health care providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

Emergency Services

Health Net and its delegated PPGs provide geographically accessible coverage for emergency services to all Members. Emergency services are for covered medical, surgical or psychiatric conditions manifesting themselves by acute symptoms of sufficient severity such that a prudent layperson with an average knowledge of health and medicine could reasonably expect serious impairment of his or her person from the presenting symptoms without such care. Emergency services are covered inpatient and outpatient services when furnished by a qualified provider and needed to stabilize an emergency medical condition. Emergency services are covered both inside and outside the plan or network and do not require pre-authorization.

Monitoring of Health Net's Performance in Providing and Management of Utilization Management Services

CHPIV monitors Health Net performance via a combination of Quality-based and Compliance-based approaches. Various metrics (e.g., prior auth denials, auth approval turn-around times) are monitored on a continuous basis. Other metrics (e.g., case file reviews) are audited on a quarterly/semiannual/yearly cadence. Health Net's performance is also reviewed via participation in various committees (e.g., Quality Improvement Health Equity Committee, UM Review Committee).

Evaluation of the Health Net UM Program Description and the UM Policies and Procedures

After Health Net completes its internal review and approval process, the CHIPV UM Program Description is forwarded to CHIPV for review and approval. This ensures that all relevant policies, procedures, and protocols are aligned and in accordance with CHPIV's standards before they are finalized and implemented. The review and approval process is a key step in ensuring the consistency, compliance, and quality of the UM program.

Section 4

Organizational Structure and Resources

Organizational Structure and Resources

Community Health Plan of Imperial Valley Staff Resources and Accountability

CHPIV Chief Medical Officer/Chief Health Equity Officer (CMO/CHEO)

The CHPIV CMO/CHEO's responsibilities include chairing the Quality Improvement Health Equity Committee and work group, providing oversight of Quality Improvement Health Equity Programs, and assuring that the Quality Improvement, Health Equity and Utilization Management Programs are compatible and interface appropriately with the provider network, overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in Utilization Management operations. This position makes recommendations to the LHA Commission to initiate major program revisions and communicates the LHA Commission's directives to both internal and external stakeholders.

Department Resources

CHPIV staff, with assistance from HNCS interdisciplinary staff, contributes to the success of the CHPIV UM Program. These administrative and clinical staff work with CHPIV's CMO/CHEO and Director of Medical Management to oversee UM activities for CHPIV's Medi-Cal Members and provider network. The resources and responsibilities of departments most involved in the UM process are described below.

Medical Management Team

The Medical Management team will include a CMO/CHEO, Director of Medical Management Services, who is a Registered Nurse, a Medical Management Manager, a Nurse Analyst, and an Administrative Coordinator to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. CHPIV and HNCS will ensure that staff involved with the Utilization Management program are appropriately trained and experienced in Utilization Management, Safety, Public Health, Health Administration, and Care Management.

CHPIV Quality Improvement Health Equity Committee

The purpose of the CHPIV Quality Improvement Health Equity Committee (QIHEC) is to provide oversight and guidance for CHPIV's QI, HE, UM, and Credentialing Programs, monitor delegated activity, and provide professional input into development of medical policies.

The QIHEC Committee monitors the quality and safety of care and services rendered to Members, identifies clinical and administrative opportunities for improvement, recommends policy decisions, evaluates the results of QI and UM activities, institutes needed actions, and ensures follow up as appropriate.

The QIHEC Committee is given its authority by and reports to the Imperial Local Health Authority (LHA) Commission in an advisory capacity. Members of the committee are appointed by the LHA Commission Chairperson. The Committee is chaired by the CHPIV CMO/CHEO.

Committee size is determined by the LHA Commission with the advice of the CMO/CHEO.

The QIHEC Committee is composed of Participating health care providers, including physicians, behavioral health practitioners, as well as other health care professional's representative of the CHPIV and the Health Net provider network. The Committee composition may also include Commission Members who are participating health care providers and shall be composed of less than a quorum of voting Commissioners. Committee Membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population and provide mental health services. Participating Practitioners from other specialty areas are retained as necessary to provide specialty input.

Health Net Organizational Structure and Resources

Health Net LLC's Chief Medical Officer has direct responsibility for the Utilization Management Program.

Population Health and Clinical Operations (PHCO) Resources

Health Net, LLC Chief Medical Officer (CMO)

The Health Net, LLC CMO's responsibilities include assuring that the QI and Utilization Management Programs are compatible and interface appropriately with the provider network; overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QI Utilization Management operations.

The CMO has overall decision-making responsibilities for Health Net medical matters. The CMO oversees, directs and coordinates all health services functions in partnership with Senior Medical Directors, Medical Directors and other PHCO leadership team Members. PHCO departments for which they have clinical oversight responsibility to include: Quality Improvement, Utilization Management, Care Management, Appeals and Grievances, Compliance, Program Accreditation and Disease/Chronic Condition Management.

The CMO's responsibilities include, but are not limited to: leading the health plan in California PHCO initiatives and corporate strategic directives; overseeing medical activities, programs and initiatives to monitor quality of care, delivery and access; directing the implementation of the Utilization Management Program; working collaboratively with other Health Net departments (e.g., Sales, Marketing, Contracting, Network Management and Pharmacy Management); leading analysis of management, financial and utilization reports to target areas for improvement; and overseeing compliance with accreditation standards and regulatory requirements.

Health Net Community Solutions (HNCS) CMO/ Vice President (VP) Medical Director

The HNCS CMO/VP Medical Director, is responsible for Utilization Management and Care Management activities for Medi-Cal. In addition, the HNCS CMO/VP Medical

Director is responsible for QI activities for these programs. The HNCS CMO/VP Medical Director is the chair of the Health Net Community Solutions Quality Improvement Health Equity Committee and is actively involved in implementing the UM Program. The HNCS CMO/VP Medical Director reports to HN LLC's CMO.

This position makes recommendations to the Health Net Community Solutions Board of Directors to initiate major program revisions and communicates Board of Directors' directives to both internal and external stakeholders.

Medical Directors

The Medical Directors administer and coordinate the overall development of medical policies, utilization and care management programs and integrating physician services with the organization's medical service and delivery systems to ensure the best possible quality care for the Health Net Members in all product lines. The Medical Directors provide input and recommendations to the various departments within the organization as to policies and procedures that impact the delivery of medical care. The Senior Medical Directors participate actively in quality improvement committees and programs to obtain and ensure continued accreditation with regulatory bodies.

Health Net Medical Directors are physicians with current, unrestricted licenses responsible and accountable for ensuring appropriate clinical relevance and focus of the Utilization Management Program for all product lines.

The Medical Directors interface with Participating Provider Groups (PPG), individual practitioners and facilities on a day-to-day basis to ensure the performance of the provider community meets established Health Net standards. They facilitate utilization review and quality improvement initiatives to ensure quality and cost-effective delivery of health services. The Medical Directors maintain effective, constructive and innovative relationships with the physician groups statewide. They provide expert clinical support and assistance to the Health Net's Utilization Management staff and other Health Net staff.

Additionally, each Medical Director recommends policy/program changes to improve performance and enhance the Quality Improvement Programs as well as serving as consultants and clinical resources to the Quality Improvement and Utilization Management staff. Committee involvement comprises of Health Net Quality Improvement and Health Equity Committee, Credentialing Committee, Peer Review Committee, Delegation Oversight Committee and Medical Advisory Council.

Vice President of Population Health and Clinical Operations (VP PHCO)

The VP PHCO is a registered nurse with experience in utilization management and care management activities. The VP PHCO is responsible for overseeing the activities of the Plan's Utilization Management and Care Management Programs. The VP PHCO reports to the Plan Chief Operating Officer. The VP PHCO, in collaboration with the HNCS CMO/VP Medical Director, assists with the development of the Utilization Management Program strategic vision in alignment with the corporate and Plan objectives, policies, and procedures.

The VP PHCO is responsible for executing the Utilization Management Program, which includes but is not limited to, pre-service, inpatient concurrent review, retrospective review and care/chronic condition management. This individual is responsible for the organization-wide implementation, assessment and measurement of utilization management activities in order to improve the quality of care and services provided to the membership.

Utilization Management (UM) Resources

Director/Senior Director, PHCO

The Directors are responsible for statewide oversight of the UM Program and:

- Oversee the daily operational processes to assure continuum of care.
- Participates in planning and development of processes and procedures to assure organizational and regulatory requirements are met.
- Ensures a patient advocacy approach with a seamless integration of services and balance within the Member's benefit structure.
- Emphasizes continuity of transition of care, assisting Members in obtaining access to care, and Member education.
- Ensures the appropriate coordination and timely CCS referrals.

Health Net UM Clinical Staff

HN UM clinical nursing staff (i.e., Review Nurses) has responsibilities, which may include but are not limited to:

- First level approvals of pre-service, concurrent and post-service approvals of care,
- Case review for inpatient, outpatient, and ancillary service requests,
- Discharge planning and authorizations for post-hospital support and care,
- Referral of potential UM denial cases to a Medical Director,
- Referral of Members to Care/Chronic Condition Management when appropriate,
- Management of out-of-area cases, and
- All UM LVN, LCSW and RN staff are under the direct supervision of a Manager, who is an RN.

Additional Resources

- Additional licensed and clerical staff supports UM activities.
- Referral of Members to County CCS offices when eligible
- Referral of Members to LTSS and Waiver Programs
- Coordination with Regional Centers to ensure Medi-Cal Members receive the full range of benefits to which they are entitled
- Coordination with CCS offices, PPG's and facilities to ensure the CCS eligible Members are receiving their full benefits through managed care and carve out programs
- Referral to Local Educational Agencies (LEA) for therapeutic and diagnostic services related to educational performance
- Coordination with County programs, such as County social services for in home support services and County mental health

- Monitoring effectiveness of delegated entities and contracted providers

The Behavioral Health Team Medical Director and Medical Staff

The behavioral health Medical Director is a board-certified psychiatrist responsible for providing clinical and administrative leadership in the area of behavioral health. In addition to overseeing the implementation of behavioral health program and clinical policies, the behavioral health team Medical Director advises the quality improvement committee/sub-committees on behavioral health issues and provides specialty consultation for UM activities as well as Appeals and Grievances.

The behavioral health team Medical Staff has duties which encompass two areas: overseeing the comprehensive quality improvement program for all aspects of BH care delivery, and ensuring that adequate and timely BH services are available to all HN Members. The behavioral health team Medical Staff works with the HN Quality Improvement/Program Accreditation Department staff to collect and analyze data on availability, access, Member satisfaction, and continuity and coordination of behavioral health care. Data are analyzed and reported to the HNCS QIHEC. The behavioral health team Medical Staff sits on the following committees: HNCS QIHEC, HN Credentialing Committee, the HN Pharmacy and Therapeutics Committee, and the HN Medical Advisory Council.

Only physicians, doctoral-level clinical psychologists (as appropriate for behavioral health reviews), and pharmacists may issue medical necessity denial determinations. All licensed staff has education, training and professional experience in clinical practice.

Health Net Community Solutions (HNCS) Quality Improvement Health Equity Committee (QIHEC)

The HNCS QIHEC reports directly to the HNCS Board of Directors. The committee is charged with the monitoring of the PHCO and quality of care and services rendered to Members within HNCS including identification and selection of opportunities for improvements, monitoring interventions and addressing UM, QI, PMH and Health Equity activities which effect implementation and effectiveness. In order to integrate UM activities into the QI system, the HNCS QIHEC quarterly reviews reports of the number and types of appeals, denials, deferrals and modifications. The Committee membership includes a designated behavioral health care practitioner for any discussion of behavioral health aspects of UM/QI. The Committee membership also includes practicing network physician representatives. The HNCS QIHEC is co-chaired by the HNCS CMO/VP Medical Director and the Chief Health Equity Officer for HNCS and meets quarterly.

Section 5

Delegation

Delegation

Health Net delegates utilization management to eligible contracted Participating Provider Groups (PPGs), contracted vendors and strategic partners (delegated partners).

Health Net has established processes in place to assess and determine the appropriateness delegation for each component of the delegated responsibilities: utilization management, credentialing and recredentialing, claims processing and payment.

Health Net has an experienced team of Compliance Auditors for oversight of delegated entities. At least annually, Delegation Oversight audits delegated partners which include file and policy and procedure reviews. Delegates are required to provide monthly turn around time reporting. This reporting is reviewed for completeness and required performance standards. The Delegation Oversight team also routinely conducts system validation checks to evaluate the delegates' data quality. If an auditor discovers a below standard performance during an auditing or monitoring activity, a Corrective Action Plan (CAP) is requested from the delegate. All CAP remediations are evaluated, tracked and validated prior to closure. These oversight processes are established to ensure compliance with Federal, State, Contractual and Health Net's criteria for delegated activities.

Outside of scheduled audits, UM Compliance Auditors, in conjunction with the Medical Directors, focus efforts on delegated partners with areas of noncompliance that indicate potential problems in the UM process to implement improvement strategies. UM Compliance Auditors evaluate and report on the effectiveness of the improvement strategy to the Delegation Oversight Workgroups (DOW)/Delegated Oversight Committee (DOC). Summary reports are provided to CHPIV's monthly Management Oversight Meeting.

Delegation Oversight Committee

The purpose of the Delegation Oversight Committee (DOC) is to provide a forum for discussion of the delegates' performance and to address significant risks with health plan leadership. During this meeting oversight activities and recommendations of the subcommittee DOW, audit results and corrective actions are discussed. As needed the DOC will discuss remedial actions specific to delegated partner(s) in order to maintain Health Net's compliance with regulatory and accreditation requirements. Remedial actions may include but are not limited to:

- Increasing oversight
- Financial sanctions through a capitation deduction
- Membership freeze
- Required change in Management Services Organization
- Denial of business expansion or changes
- De-delegation, and/or contract termination
- Terminating the organization's contract with Health Net.

Sub-delegation

Delegated partners are obligated to provide oversight and documented evidence of monitoring the utilization review process whenever a sub-delegated provider and/or review organization perform this process. The delegate is required to document evaluation of the following oversight of the sub-delegate activities:

- Written agreement to participate in the delegate evaluation process by the sub-delegate.
- Approval of the sub-delegated contractor's utilization management program.
- A signed sub-delegation agreement.
- Mechanisms for evaluating the sub-delegate's program reports.
- Concise documentation of all utilization management activities that are delegated to a sub-delegate.
- Adherence to reporting requirements by oversight of the sub-delegate.
- At least annual review of the sub-delegate’s program.

A review of the contracted delegates shall be conducted annually or more frequently as needed. Documentation of these oversight activities shall be maintained by the delegate but must be available for Health Net’s review upon request.

Section 6

Utilization and Care Management (UM/CM) Program Evaluation

UM/CM Program Evaluation

Health Net's Vice President of PHCO annually prepares the CHPIV Utilization/Care Management Program Evaluation and presents the evaluation to CHPIV for review.

The annual evaluation of the CHPIV Utilization/Care Management Program provides structure for the determination of program effectiveness and the impact of the program on Members and providers. The process identifies program strengths and barriers, improvement opportunities and activities not completed, in addition to assessing demographics and effectiveness of the UM/CM Program initiatives.

The process of evaluation includes a comparison of the results of utilization/care management improvement activities against past year's performance. The evaluation documents evidence of resolution of identified problems or areas needing improvement.

Additional sources of data utilized to obtain feedback from providers and Members on CHPIV Utilization/Care Management Program and to identify opportunities for improvement include:

- Member grievances
- Member appeals
- Results of Member satisfaction surveys
- Provider appeals
- Provider grievances
- Provider satisfaction surveys
- UM decision making timeliness
- Identification and referral of Members eligible for carve-out programs
- HEDIS results
- Information from QI studies
- Joint Operation Meeting information
- PPG Report Cards
- Data and other feedback from Public Health-Linked Programs
- Over and under utilization
- Community Advisory Councils

UM/CM Program Work Plan

Health Net Community Solutions CMO/VP Medical Director and Vice President Population Health and Clinical Operations annually develop the CHPIV UM/CM Work Plan using the previous year's evaluation and adding new UM/CM activities when appropriate. The development of the work plan provides a disciplined approach to UM/CM activity monitoring. The work plan process also encourages measurement throughout the year of progress towards the outlined plan.

Section 7

Approvals

Imperial Local Health Authority Approval

Imperial County Local Health Authority Commission has reviewed and approved this Program Description.

_____ _____
Lee Hindman, Imperial County Local Health Authority Commission Chairperson — Date

_____ _____
Gordon Arakawa, MD, PhD
Chief Medical Officer/Chief Health Equity Officer
Chair, Community Health Plan of Imperial Valley QIHEC Committee — Date

Health Net Medi-Cal Utilization Management Program Approval

The Chief Medical Officer and Vice President of Medical Management have reviewed and approved this Program Description.

_____ Date _____

Alex Chen, MD
Chief Medical Officer

_____ Date _____

Brenda Belmudez
Vice President of Population Health and Clinical Operations

Community Health Plan Imperial Valley Quality Improvement and Health Education Program Description

2025

Table of Contents

I. Introduction and Background

A. Health Plan and Membership

The Imperial County Local Health Commission (LHC) is a local public agency. Under California's Medi-Cal managed care program, the LHC dba Community Health Plan Imperial Valley ("CHPIV") is designated as the Local Initiative. CHPIV is contracting with Health Net Community Solutions (HNCS, Health Net, or The Plan), a National Committee for Quality Assurance (NCQA) accredited Medi-Cal managed care plan, for capitated provider services, network, and administrative services to be provided for CHPIV's membership.

CHPIV recognizes the challenges posed by the diverse ethnic, cultural and health needs of Medi-Cal beneficiaries in the Imperial Region. CHPIV, in conjunction with HNCS, has the network, staff, knowledge, systems, infrastructure and cultural and linguistic competence to serve members in the Imperial Region and meet those challenges. As such, CHPIV is well prepared to serve Medi-Cal beneficiaries in Imperial County with quality care through evidence-based practices that emphasize preventive care and encourages self-management for healthy behaviors.

The CHPIV Quality Improvement and Health Education Program (QIHEd Program) provides members with access to network-wide, safe, clinical practices and services and ensures they are given the information they need to make better decisions about their healthcare choices. The QIHEd Program is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis and to support identification and pursuit of opportunities to improve health outcomes, services and member and provider satisfaction. Opportunities for improvement are identified through continuous monitoring of clinical outcomes, safety, access and service. The QIHEd Program employs an organizational structure that reports to the Quality Improvement/Health Equity Committee (QIHEC) and Local Health Commission and is led by committed decision-makers. The QI Program functions in collaboration with multiple departments that have QI-related functions. CHPIV also collaborates externally with network physicians, other provider types and community partners for effective QI integration process. This includes collaborative activities with participating provider groups (PPGs) and provider clinics to complete performance improvement projects (PIPs) and Plan, Do, Study, Act (PDSA) projects to close care gaps and improve provider performance and quality of care for members. Quarterly reports of these activities and outcomes are presented to the QIHEC.

CHPIV works with stakeholders in Imperial County to develop unique programs tailored to the region's needs and continues to interact with the families, health care providers and county administrators to ensure the programs achieve their goal of providing access to needed health care services.

B. Mission

We are working with community residents and stakeholders in both the public and private sectors to:

- Advance opportunities for improved health and access to comprehensive health care services
- Promote the long-term viability of safety net providers
- Increase prevention, education, and early intervention services, and

- Partner with Medi-Cal managed care plans to monitor and improve the local healthcare system.

C. Purpose

Quality Improvement Purpose

The CHPIV QI Program establishes standards for both the quality and safety of clinical care and service, as well as monitors and evaluates the adequacy and appropriateness of health care and administrative services on a continuous and systematic basis. The QI Program also supports the identification and pursuit of opportunities to improve health outcomes, and both member and provider satisfaction.

Health Education Purpose

The CHPIV Health Education (HEd) System provides accessible no cost health education programs, services and resources based on the community health, cultural, and linguistic needs of the CHPIV members and contractually required program scope.

D. Goals

Quality Improvement Goals

- Ensure promotion of safe, high-quality care and services while maintaining full compliance with standards established by regulatory and accreditation agencies.
- Objectively and systematically monitor services provided to members to ensure conformity to professionally recognized standards of practice and codes of ethics.
- Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
- Develop and implement an annual quality improvement work plan and continually evaluate the effectiveness of plan activities aimed at improving and maintaining performance of target measures, and act as need, to improve performance
- Support partnership between members, practitioners, providers, regulators to provide effective health management, health education, disease prevention and management, and facilitate appropriate use of health care resources and services.
- Design, implement and measure organization-wide programs that improve member, practitioner and provider satisfaction with Health Net's clinical delivery system. These programs are population-based, ongoing, clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines, and care management programs.
- Monitor and improve performance in promoting quality of service to improve member and provider satisfaction through the use of satisfaction surveys, focused studies, and analysis of data (e.g., administrative, primary care, high-volume specialists and specialty services, and mental health and substance use disorder services).
- Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the integrity of data collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.
- Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.

- Provide a means by which members may seek resolution of perceived failure by practitioners and providers or health plan personnel to provide appropriate services, access to care, or quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate.
- Ensure the development of strategies and processes designed to improve health equity and mitigate health disparities.

Health Education Goals

- To provide culturally and linguistically appropriate health education programs and resources at no cost.
- Support CHPIV members and the community to achieve optimal physical and mental health.
- Promote health equity.
- Improve CHPIV's quality performance.
- Enhance member satisfaction.
- To engage communities, stakeholders and partners by providing high quality health education programs and resources.

II. Scope

A. Overview

The QIHEd Program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance. The scope of these activities considers the enrolled populations' demographics and health risk characteristics, as well as current national, state and regional public health goals. The Population Health Management (PHM) strategy provides a unifying framework to support the QIHEd Program in delivering a whole-person approach to caring for CHPIV members.

Health education interventions are based on community health and cultural and linguistic needs to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health and dental care services, and to follow self-care regimens and treatment therapies. Health education services include individual, group or community-level education and are supported by trained health educators and public health professionals to encourage immediate positive knowledge gain and healthy behavioral intentions. Health education programs include individual, community or population-based initiatives designed to encourage long-term behavioral changes for positive health outcomes. Provision of health education resources includes culturally and linguistically appropriate brochures, flyers, posters, newsletters, presentations, website articles, and social media resources. The framework uses risk stratification data compiled from a variety of data sources to help teams target the right members with the right resources to address member health and social drivers of health (SDoH) needs at all stages of life.

The QIHEd Program impacts the following:

- **CHPIV Members** in all demographic groups and in the service areas for which Community Health Plan of Imperial Valley is licensed.

- **Network Providers** including practitioners, facilities, hospitals, ancillary providers, and any other contracted or subcontracted provider types.
- **Aspects of Care** including level of care, health promotion, wellness, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and services covered by CHPIV.
- **Health Disparities** by supporting activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities.
- **Health Education** by providing accessible no cost health education programs, services and resources based on the community health, cultural and linguistic needs of members and contractually required program scope and by monitoring the quality and accessibility of health promotion and education resources made available to members by Health Net's subcontracting/delegated vendors, Participating Provider Groups (PPG), and Primary Care Physicians (PCPs).
- **Communication** to meet the cultural and linguistic needs of CHPIV members.
- **Behavioral Health Aspects of Care** integration by monitoring and evaluating the care and service provided to improve behavioral health care in coordination with other medical conditions.
- **Practitioner/Provider Performance** relating to professional licensing, accessibility and availability of care, quality and safety of care and service, including practitioner and office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.
- **Services Covered by CHPIV** including preventive care, primary care, specialty care, telehealth, ancillary care, emergency services, behavioral health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, Health Homes Program (HHP), long term care (LTC), Long Term Services and Supports (LTSS): Community Based Adult Services (CBAS), CalAim benefits, and Multi-purpose Senior Services Program (MSSP) that meets the special, cultural and linguistic, complex or chronic needs of all members.
- **Internal Administrative Processes** which are related to service and quality of care, including customer services, enrollment services, provider relations, practitioner and provider qualifications and selection, confidential handling of medical records and information, care management services, utilization review activities, preventive services, health education, information services and quality improvement.

B. Provider Network

In the Imperial Region, CHPIV partners with HNCS to maintain contracts with a full range of providers and vendors including acute care hospitals, home health care companies, infusion therapy and dialysis companies, durable medical equipment vendors, outpatient surgery facilities, radiology/imaging centers, skilled nursing facilities, acute and sub-acute rehabilitation facilities, laboratory services, outpatient pharmacies, and hospices. HNCS also arranges health care through direct contracts with certain health care providers. In the Imperial Region, all of the provider contracts are a mix of fee-for-service (FFS), capitated delegated, and capitated non-delegated models.

C. Preventive Screening Guidelines (PSGs)

CHPIV adopts nationally recognized preventive health guidelines for health maintenance, improvement and early detection of illness and disease for children and adults. The guidelines are reviewed, updated, and adopted on an annual basis or more frequently when new scientific evidence or national standards are published prior to the scheduled review

date. CHPIV along with delegated Health Net Medical Directors with various medical specialties are involved in the adoption of the guidelines. New members receive the Preventive Health Screening guidelines in the new member welcome packet and new providers receive this information with orientation materials within 10 days of becoming authorized to see members. The guidelines inform members of health screening and immunization schedules for all ages. These are available in all threshold languages. Printed guidelines are available to existing practitioners and providers online and for members by calling 1-833-236-4141. The Preventive Screening Guidelines are communicated to all members and network providers annually and are updated and posted on the member and provider portals.

Preventive services are monitored through the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data Information Set (HEDIS®) and other programs as specified in the QIHEd Work Plan. In collaboration with physicians and providers, CHPIV encourages members to utilize health promotion and preventive care services.

D. Clinical Practice Guidelines

CHPIV adopts and disseminates evidenced-based clinical practice guidelines that are relevant to its membership for the provision of preventive and non-preventive health care services, acute and chronic medical services and behavioral health services. These clinical practice guidelines assist practitioners, providers and members to make decisions about appropriate health care for specific clinical circumstances, to improve health care, and to reduce unnecessary variations in care.

CHPIV adopts guidelines from recognized organizations that develop or disseminate evidence-based clinical practice guidelines. These include professional medical associations, voluntary and other health organizations such as the National Institutes of Health (NIH) and the U.S. Preventive Services Task Force (USPSTF). Input from specialists is obtained as necessary and clinical practice guidelines are reviewed and approved by Health Net's Medical Directors, (through the Health Net Medical Advisory Council), and CHPIV's CMO and the QIHEC. The guidelines are updated and revised at least every two years or more frequently when new scientific evidence or national standards are published.

Guidelines are evaluated for consistency with CHPIV's benefits, utilization management criteria, and member education materials. They are communicated to providers through provider updates and are available to providers on the Health Net websites and to members upon request. CHPIV monitors adherence to guideline recommendations and program outcomes using HEDIS measures.

E. New Technologies

CHPIV has a formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages.

The Change Healthcare InterQual® criteria, the HAYES Technology Directory and other evidence-based resources are used as primary sources. This includes:

- Nationally recognized drug compendia resources such as American Hospital Formulary Service-Drug Information (AHFS DI®), Facts & Comparisons®, Clinical Pharmacology®, DRUGDEX®, Lexi-Drugs®, and the National Comprehensive Cancer Network® (NCCN®) Guidelines.
- Medical association publications, government-funded, or independent entities that assess and report on clinical care decisions and technology, including Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, and National Institute for Health and Care Excellence (NICE).

CHPIV leverages its delegated entity's (Health Net) primary sources, including Centene's (Health Net's corporate organization) Corporate Clinical Policy Department and Clinical Policy Committee along with Health Net of California's Medical Advisory Council. They are responsible for the evaluation of new technology that may be sought by CHPIV members. A critical appraisal of the current published medical literature from peer-reviewed publications is undertaken to assist in the evaluation of medical technology.

F. Population Health Management (PHM)

Annually, through the PHM Program, CHPIV evaluates the needs of its enrolled population and uses that information to assess whether current programs need modification to better address the needs of its membership. CHPIV's PHM Program examines data through population risk stratification using a predictive modeling tool that utilizes data from various sources including medical and behavioral claims and encounters, social needs data, pharmacy claims, laboratory results, health appraisal results, electronic health records (EHRs), data from health plan UM and/or CM programs, and advanced data sources such as all-payer claims databases or regional health information. The data are used for:

- Evaluation of the characteristics and needs of the member population including an analysis of the impact of relevant SDoH.
- Evaluation of health status and risks by using utilization data broken out into at least the following cohorts based on the enrolled product lines: birth to age 18, age 19 to 64 and ages 65 and over.
- Evaluation of the needs of members with disabilities.
- Evaluation of the needs of member with severe and persistent mental illness.

Data combined with SDoH and QI data (e.g., HEDIS care gaps), are reported to facilitate an understanding of similarities and differences in health needs and status. When the data analyses are complete, they are used to determine if changes are required to population health management (PHM) programs or resources. In addition, there is an evaluation of the extent to which population health management programs facilitate access and connection to community resources that address member needs outside the scope of the health benefit plan. Modifications to program design and resources are made based on these findings. The Risk Stratification, Segmentation, Tiering (RSST) methodology identifies significant changes in Members' health status or level of care and in this way, Members are monitored to ensure appropriate re-stratification and connection to chronic disease management, care management, enhanced care management (ECM), complex care management (CCM), community supports (CS) and other programs. Outcomes data is stratified by race, ethnicity, language, and age on a plan-level including emergency room (ER)/inpatient (IP) utilization, ambulatory and preventative visits within a 12-month period, enrollment into CCM, and transitions for high-risk member having connection with their assigned care manager.

The PHM operations team is a cross-unit operations team composed of talent from multiple departments and is led by a core team of a Medical Director and a Pharmacist. The team is accountable to the QIHEC.

Basic Population Health Management

CHPIV's Basic Population Health Management (BPHM) services support the ongoing, seasonal, episodic, and occasional needs of our members to ensure appropriate care. Using a multi-pronged, non-delegated, empanelment approach to BPHM, we directly facilitate connections to primary care. New member welcome packets are sent to ask members to schedule their initial health appointment (IHA) and conduct new member outreach to facilitate appointment scheduling, and survey members to ensure they are satisfied with their assigned providers. Primary care providers (PCPs) are also notified of new member enrollment within 10 days of assignment to facilitate PCPs seeing their patients within 120 days of assignment. Members who do not select a PCP within 30-days of enrollment are auto-assigned a PCP within 40-days of enrollment. (Full-benefit dual-eligible members are not required to select a Medi-Cal PCP).

The Plan proactively outreaches to members without a PCP visit in the past year to assist in arranging appointments, transportation, or interpreters, if needed. Hard-to-reach members, including those with unstable housing or no phone, are assigned to the Plan's MemberConnections Field Team or contracted Community Health Worker Organization for in-person outreach. The MemberConnections Representatives (MCR) also assist with PCP selection or change. Members are informed that they can select a variety of providers in lieu of a PCP (e.g., Nurse Practitioner, Certified Nurse Midwife, Physician Assistant).

Chronic Conditions Management

CHPIV offers an integrated care management program to members that address members' physical, behavioral, and psychosocial needs. Care managers support members to increase their awareness of self-care strategies and empower participants to manage their chronic conditions. This program includes a population-based identification process, risk stratification, interventions based on clinical need, patient self-management, disease education, and process and outcome measurement. Multi-disciplinary teams are involved in the development of these efforts. Referrals to care management programs are multichannel and come through provider and member self-referrals. Members enrolled in the care management program with chronic conditions are included in the integrated care model.

CHPIV's delegate's corporate partner, Centene's Population Health Management Office, conducts chronic conditions management for members with designated diagnoses. The program includes member stratification, disease education, and promotion of self-management principles. Members requiring additional support are referred to Care Management.

Complex Health Needs/Care Management

CHPIV is committed to serving members with complex medical or behavioral health needs through coordinating services and assisting them in accessing needed resources.

CHPIV provides care management for Medi-Cal including seniors and persons with disabilities. The goal of Care Management is to support members in achieving optimum

health, functional capability, and quality of life through improved management of their disease or condition, and access to available resources.

Members in Complex Care Management have typically experienced a critical event or have a complex diagnosis that may be compounded by SDoH requiring oversight and coordination of care with practitioners, providers and/or community and social service agencies. Members are identified using Health Net data sources and may also be referred into the program via multiple avenues, such as:

- Health information
- Internal program
- Discharge planning referral
- Utilization management referral
- Member or caregiver self-referral
- Practitioner referral, and
- Ancillary providers (e.g., home health, physical therapy, occupational therapy).

Members undergo a comprehensive assessment, which is used to develop a care plan that meets their specific complex care needs. Care plans focus on the member's prioritized needs including monitoring the patient's understanding and adherence to the plan of care, identification and removal of barriers to care, achievement of short- and long-term goals, and restoration of the highest functional level that is possible for the patient.

G. Behavioral Health Services

CHPIV delivers covered mental health services to the majority of its members through Health Net. Health Net contracts directly with psychiatrists as well as non-MD behavioral health specialists and is delegated to perform certain functions (e.g., credentialing, claims, utilization management, etc.).

CHPIV and HNCS are taking a collaborative approach to educate providers and members on the importance of:

- Coordination of care and exchange of information between medical and behavioral health providers and county mental health plans.
- Diagnosis, treatment, and referrals of members with mental health and substance use disorders to network specialists, county mental health plans, County Drug and Alcohol Programs and other resources as appropriate.
- Appropriate uses of psychopharmacologic medications and treatment adherence.
- Managing coexisting conditions and behavioral health preventive programs.

These areas are measured through the following sources to identify new initiatives or opportunities to enhance existing interventions:

- Member survey to assess satisfaction with and access to covered mental health services.
- Provider survey to assess satisfaction with the timeliness and usefulness of information from behavioral health practitioners, along with their experience with coordination of care.
- Network availability and adequacy of behavioral health providers.
- Member quality of care and service complaints investigation.

- Evaluation of behavioral health HEDIS measures and other QI behavioral health initiatives.

H. Operations and Service

CHPIV's delegate, Health Net, evaluates the adequacy, effectiveness, and timeliness of internal operations against established standards to identify strengths and opportunities to improve member, practitioner, and provider satisfaction. Standards are based on regulatory and accrediting bodies.

Health Net/CHPIV also monitors access to services and availability of the practitioner and provider network, member grievance and appeals, member satisfaction surveys, practitioners and provider satisfaction surveys, marketing material accuracy and provider feedback through Provider Engagement, and Provider Performance & Analytics, and Provider Network Management departments.

Quality improvement activities focused on service and internal operations rely on multi-departmental involvement in the QIHEd Program. Activities involve associates from Population Health and Clinical Operations, Pharmacy, Health Equity, Appeals and Grievances, Customer Contact Center, Credentialing, Provider Network Management, Provider Engagement, Provider Performance & Analytics, Claims, Compliance, Privacy, Program Accreditation, Sales and Marketing Departments.

I. Health Plan Performance

CHPIV conducts ongoing monitoring of health plan performance by participating in annual HEDIS measurement, member and provider satisfaction assessments, monitoring of appeals and grievances, and evaluating the accessibility and availability of medical services. CHPIV maintains a broad range of key performance and operational metrics to monitor clinical and service quality in Appeals & Grievances, Customer Service, Population Health and Clinical Operations (PHCO) which includes Utilization Management, Care Management, Concurrent Review, and the Medical Review Unit. CHPIV's QI Program also monitors key performance metrics for Pharmacy.

CHPIV is pursuing NCQA Health Plan Accreditation by 2026.

CHPIV's QI Program also has established metrics for key operational processes, such as Claims and Customer Service, and monitoring for service improvement opportunities.

CHPIV monitor HEDIS rates, access and availability standards, quality of care incidents, and CAHPS/ECHO results to assess practitioner and provider adherence to best practices and prioritize health plan outreach activities and campaigns. CHPIV emphasizes the importance of technology/Electronic Health Records (EHRs) enabling providers to track and remind patients about regular health screenings. Multiple activities may be in place to improve outcomes, promote safety, increase screening and improve performance metrics. Examples are included in the following list (refer to the QI and HEd Annual Work Plan section for more details):

- Practitioner and provider outreach to improve exchange of quality performance data.
- Member and provider outreach to share quality performance ratings.
- Development of tools to assist practitioners and providers to improve performance.
- Hospital quality monitoring for hospital acquired conditions.

J. Credentialing / Recredentialing

CHPIV has established policies and standards to ensure the selection and retention of qualified practitioners and providers. Policies have also been developed for oversight of those organizations delegated to manage the credentialing of practitioners. Recredentialing is initiated and completed within 36 months of the previous committee decision and incorporates a 3 year look back review of peer review and member activity that assists the Credentialing Committee in making an informed decision.

Compliance issues are reported to CHPIV's Chief Medical Officer. The Chief Medical Officer will work with CHPIV Chief Compliance Officer and CHPIV's QIHEC to address such compliance issues.

All providers undergo a quality process of credentialing prior to finalizing contract agreements and are recredentialed every three years. All providers are monitored monthly for Medicaid plan sanctions, license disciplinary actions, quality of care and service incidents, and any other adverse actions. Trendable actions and any high severity leveled cases are reported to the Peer Review Committee where further actions are taken.

Ongoing monitoring occurs after the practitioner's initial inclusion to our network begins and occurs monthly, to ensure our plan can take immediate action to protect our members and maintain compliance with all regulatory agencies. We take action within 30 calendar days of the released report:

- Member complaints and quality of care service tracking and trending,
- Medicaid sanctions.
- Federal Department report.
- OI/LEIE: The Office of Inspector General list of excluded entities/listing of excluded Medicaid providers.
- State Medical Board disciplinary action reports.
- Medi-Cal Suspended and Ineligible list (SIPL).
- Restricted Provider Database (RPD).
- Ongoing office monitoring.

Any delegates with continued compliance issues are reported to CHPIV's delegated plan, Health Net's Delegation Oversight Committee. The Delegation Oversight Committee is a subcommittee of HNCS QIHEC. The Health Net Appeals and Grievances Department works with the Credentialing and the Peer Review teams to report on potential and substantiated quality of care issues. All practitioners and providers undergo a quality process of credentialing prior to finalizing contractual agreements and are recredentialed every three years. All practitioners and providers are monitored monthly for Medicaid sanctions, license sanctions, limitations and expirations, quality of care and service incidents, and any other adverse actions. Trended issues and high severity level cases are reported to the Peer Review Committee for review and determination.

K. Continuity and Coordination of Care

A major focus of CHPIV's QI program is ensuring that the care members receive is seamless and integrated. These activities can be divided into the following main areas:

- Across medical care settings that include (but are not limited to) outpatient, inpatient, residential, ambulatory, CBAS centers, and other types of locations where care may be provided.
- Transition between practitioners when practitioners leave the network or changes their health care setting.
- Continuity and coordination between medical care and behavioral health care.
- Referral and coordination with Medi-Cal carved out service providers.

CHPIV, in conjunction with HNCS, identifies opportunities for improvement in continuity and coordination of care through various methodologies, including but not limited to:

- Member satisfaction surveys
- Appeals & Grievance data analysis
- Provider satisfaction surveys
- HEDIS measures, and
- Medical record review.

For all members with identified complex health needs, CHPIV supports their continuity and coordination of care through an integrated healthcare model that provides the level of care management the member needs based on acuity and includes the care management of behavioral health conditions. The nurse advice line also addresses member triage needs 24 hours a day, seven days a week. Provider groups also support members through their coordination of care programs.

Mechanisms are implemented to monitor and facilitate continuity and coordination of care for members. These activities include, but are not limited to:

- Care Management
- Pharmacy programs
- Utilization Management
- Member Services functions
- Communication and data exchange that is appropriate and compliant with state and federal privacy and security regulations, and
- Information will be posted on the Plan website for advising providers, contractors, members, and the public how they can obtain information about the UM processes and guidelines used to authorize, modify, or deny health care services under the benefits provided by CHPIV.

L. Delegation

CHPIV has an Administrative Services Agreement (“ASA”) with HNCS to provide certain administrative services on CHPIV’s behalf (e.g., Quality Improvement, Health Education, utilization management, appeals and grievances, Population Health, claims, credentialing, member/provider services, care management, Pharmacy, behavioral health, and Provider Network Management etc.).

CHPIV evaluates the Plan’s ability to perform Quality Improvement functions by means of a robust delegate oversight process. In its delegate oversight process, CHPIV performs continuous monitoring and regular audits. CHPIV has designated Quality Improvement auditors specially trained to perform these evaluation functions. QI auditors evaluate and monitor delegated entities annually, or more frequently if needed, to ensure compliance with

Federal, State, Contractual, and applicable NCQA standards. When the monitoring and auditing process identifies gaps between performance targets and actual performance, root cause analysis will be completed, and corrective action plans (CAP) created. Follow-up monitoring and auditing are performed to ensure the CAPs are completed and performance gaps are resolved.

M. Safety

CHPIV is committed to ongoing collaboration with network providers, facilities and external accrediting agencies to build a safer health system. Current member or patient safety initiatives include:

- Responses to quality of care issues for which an investigation of complaints is conducted, and action taken where applicable. Analyses of overall and individual trends are conducted.
- Monitoring reportable hospital events and investigation of quality of care issues as appropriate.
- Providing educational information to members and practitioners on safe health practices.
- Credentialing and recredentialing to ensure only qualified practitioners and organizations provide care to members.
- Practitioner office site reviews in accordance with established criteria to ensure the environments are safe, clean and accessible for members.
- Clinical practice guidelines distributed to network providers; CHPIV evaluates and makes decisions on utilization management, member education, coverage of services, and other areas to be consistent with CHPIV's clinical guidelines.
- Careful review of member complaints and member satisfaction surveys related to member safety to ensure action is taken when applicable.
- Care Management conducts activities to ensure that continuity and coordination of care are provided for high-risk members.
- Pharmaceutical information is available for practitioners about member-specific topics and new medications. The Pharmacy Department also conducts utilization reviews and develops quality initiatives related to prescription drugs and best practices.
- Prescription drug information is available on the member portal/website about generic and brand names, warnings, side effects, precautions, drug-drug interactions, overdose information and what to do if a dose is missed.
- Improvement initiatives that promote safety, such as the patient safety QI program which includes hospital-acquired condition monitoring and reducing hospital-acquired infections, reducing unnecessary C-sections, promoting Cal Hospital Compare's Honor Rolls, fall prevention, and medication adherence.
- Delegating to Health Net participation in collaborative efforts to improve care with organizations such as The Leapfrog Group, the California Maternal Quality Care Collaborative (CMQCC), California Quality Collaborative (CQC), Cal Hospital Compare, Cynosure Health, collaboration with other health plans, HICE (Health Industry Collaboration Effort); CAHP (California Association of Health Plans), Department of Managed Health Care (DMHC) and/or Department of Health Care Services (DHCS) Quality Collaborative meetings with other health plans, and Integrated Healthcare Association (IHA).

N. Health Equity and Cultural and Linguistic Needs

CHPIV will work very closely with Health Net to address Health Equity and Cultural and Linguistic Needs. Health Net utilizes the Cultural and Linguistic Appropriate Services (CLAS) Standards, developed by the Office of Minority Health, as a guide for provision of culturally and linguistically appropriate services. CLAS Standards assure that services comply with the Office of Civil Rights Guidelines for culturally and linguistically appropriate access to health care services (Title VI of the Civil Rights Act). Health Net's objective is to promote effective communication with limited English proficient CHPIV members by assuring access to culturally appropriate materials, print translations of member informing materials, telephonic and in-person interpreter services, and through culturally responsive Health Net associates and health care practitioners and providers.

At least every two years, Health Net completes an analysis of the cultural and linguistic needs of the membership. Data sources may include the following:

- Membership demographic data
- Call center data
- Appeals and grievance information, and
- Geo Access analysis of provider network language capabilities.

These data sources are used to analyze members' cultural and linguistic needs when developing communications to promote quality and health promotion activities and meet contractual obligations established by regulatory and accrediting bodies.

CHPIV and Health Net is aware of the diverse culture of California and is fully compliant with the contract requirements related to California's Department of Health Care Services (DHCS) regulatory agency Medi-Cal Managed Care Division (MMCD) Policy Letters, DMHC, and Department of Insurance (DOI) regulations for language assistance services and federal rules that require the provision of language assistance services. Additionally, it will ensure processes to meet contractual and regulatory cultural and linguistic requirements identified by Centers for Medicare and Medicaid Services (CMS), and other regulatory and oversight entities.

At least annually, CHPIV and Health Net informs members, practitioners and providers of the availability of the Language Assistance Program (LAP), which offers language assistance services at no cost to members, including how to access the services and their rights to file grievances, in compliance with legal, contractual, regulatory agency, and oversight agency guidelines. Semi-annually, the LAP is monitored; this report includes trend analysis of grievances, and summary of language preferences. Health Net quality committees approve the appropriate quality benchmarks, review language preference results, and make recommendations for incorporating language preference into QI, and health education programs, follow-up actions or corrective action plans as needed. This process is managed by the Health Equity team.

A Geo Access assessment is conducted using member zip code data and correlated with member language preference every two years. The language capabilities of the practitioner and provider network are compared to the language needs of CHPIV members. The availability of linguistic services by contracted providers for limited English proficient members is analyzed and recommendations are made to further enhance the promotion of available language services in support of members, practitioner and provider network.

Contracted practitioners and providers are informed of the cultural and linguistic services available via Provider Updates and the Provider Operations Manual. Culturally informative materials, trainings, and in-services are provided to network practitioners and internal department associates periodically. The Health Net Diversity, Equity, and Inclusion Training Program addresses the delivery of services in a culturally competent manner to all members, including prohibiting discrimination based on national origin, race, color, ancestry, ethnic group identification, sex, sexual orientation, marital status, gender, gender identity, age, physical disability, mental disability, religion, language, medical condition, or genetic information.

The Health Equity and Health Education System complete a Medi-Cal Population Needs Assessment every three years to determine member demographics, health risks and health care needs. Assessment findings are used to develop appropriate health education, cultural and linguistic, and quality improvement interventions to meet members' needs.

Health Net was the first health plan in California to obtain NCQA's Multicultural Health Care (MHC) Distinction for all products, in 2011. In 2022, Health Net was awarded Health Equity Accreditation (HEA) and HEA Plus and was renewed on September 2024.

CHPIV will work with Health Net to implement strategies to support the reduction of health disparities in clinical areas. Health Net facilitates health equity workgroups that are responsible for developing and implementing an action plan to reduce targeted health disparities. The health disparity reduction initiatives are aligned with requirements from NCQA HEA and HEA Plus, MediCal contract requirements and Health Net internal directive to address health disparities. Disparity reduction actions are implemented through a model that integrates Health Net departments across Quality Improvement, Provider Engagement, Health Equity, Health Education, Wellness, regional clinical teams, and Public Programs. The model utilizes a multidimensional approach to improving quality and delivery of care inclusive of community outreach, member and provider interventions as well as system level initiatives. The following highlights the core components of the disparity reduction model:

Commented [CM1]: @Dao M. Fang What are the Exchange requirements? Is this part of Marketplace or does this refer to something else entirely? If it does refer to Marketplace, does it belong in the CHPIV program description, since this should just be for Medi-Cal?

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- Planning inclusive of data analysis (spatial and descriptive), data validation, key informant interviews, literature reviews, development of community and internal advisory groups, and budget development.
- Implementation of actions targeting three core levels: 1) Member/Community where partnerships are formed to identify existing initiatives and leverage support of community feedback to design and implement interventions; 2) Provider interventions targeting high-volume, low-performing groups and practitioners who have disparate outcomes; and 3) Internal programs to improve disparities in identification, engagement and outcomes in Care Management and chronic conditions management.
- Evaluation and improvement of health disparity efforts is conducted using process and initiative level evaluation.

Health Net employees can be involved in Centene's national employee inclusion groups (EIG) for veterans, military families, women, LGBTQ+ community, multicultural network, and people with disabilities, and across life stages. The EIGs have community engagement subcommittees that may indirectly impact health equity efforts and support employees in addressing health disparities within their communities.

Health Net is committed to supporting CHPIV diversity, equity, inclusion, and cultural humility and eliminating health inequities and disparities by working to break down the barriers that prevent access to high-quality health care services. Through its Health Equity (HE) and HEA Plus programs and services, the organization is committed to finding solutions and providing appropriate resources and interventions to diverse individuals within its population and community. Finally, the organization is committed to CLAS and addressing social risks and needs by:

- Establishment of the Executive DEI Council
  - Composed of senior leaders from our business divisions, focuses on strategic accountability across DEI core pillars
  - Widespread distribution and presentation of the Diversity, Equity, and Inclusion (DEI) Annual Report, which reflects our commitment to DEI at Centene and demonstrates Centene's tangible steps to achieving a more inclusive workplace
  - Ensuring policies and practices drive sustainable DEI results throughout the enterprise
  - Advocating for systemic change that embodies social justice, public policy, equity, and inclusion
  - Historically, the council has taken action to focus on the following priorities:
    - leadership development and accountability,
    - pay equity,
    - cultural inclusivity,
    - local business unit DEI council development, and
    - enterprise access to DEI resources.
- Embracing diversity without bias or discrimination.
- Supporting and strengthening equitable care through fair distribution in procedures, resources, systems, and mechanisms.
- Actively including, sharing, and engaging diverse individuals, groups, teams, partner organizations, and community members by providing on-going opportunities and pathways for participation in decision-making processes.
- Exhibiting respect for and value of diverse cultural health beliefs, behaviors, and needs of individuals and the community through responses and interactions when providing services to others.
- Partnership with findhelp to support social needs assessment and community social risk identification.

The Health Equity department services in support of staff include Diversity, Equity, and Inclusion Training Program, in-services, and cultural awareness events. Cultural awareness in-services are provided upon hire to all Member Services staff. In addition, the Health Equity Department collaborates with internal departments such as Provider Engagement, Provider Network Administration, Health Education, and Quality Management to provide in-service of C&L/health equity services and/or Diversity, Equity, and Inclusion Training Program. As needed, Health Equity also provides in-services to case managers to assist in building trust with patients who are recently arrived immigrants. The goal of these in-services is to provide information to staff on the cultural and linguistic requirements, non-discrimination requirements, the LAP, C&L and health equity resources and CHPIV member diversity.

The Health Equity Department supports contracted providers in their efforts to provide culturally responsive care to members. The services offered to contracted providers are intended to:

- Encourage cultural responsiveness and awareness.
- Provide strategies that can easily be implemented into clinical practice.
- Foster improved communication and health outcomes for patients from diverse cultural and ethnic backgrounds, with limited English proficiency, disabilities, regardless of their gender, gender preference or gender identity.
- Foster non-discrimination based on national origin, race, color, ancestry, ethnic group identification, sex, sexual orientation, marital status, gender, gender identity, age, physical disability, mental disability, religion, language, medical condition, or genetic information.

Trainings for providers and their office staff are currently available for the following topics:

- Advancing Health Equity: Diversity, Humility and Equity in Healthcare
- Bridging Linguistic and Cultural Gaps for Equal Access to Health Care
- Health Literacy/Plain Language
- Gender Inclusive/Affirming Care
- Community Connect Program-Social Needs Support, and
- Language Assistance Program/Services and Health Literacy.

O. Access and Availability

CHPIV has established access to care standards for health care services in accordance with the regulatory and accrediting laws and regulations. These standards ensure CHPIV provider network has sufficient numbers and diversity to provide all members with appropriate access to and availability of practitioners, providers, health care services, and language assistance services. These standards also ensure CHPIV members have appropriate access to medical services including primary care, specialty care, and behavioral care appointment access, after-hours access and instruction, urgent and emergent care, ancillary services access, and telephone customer service within a reasonable distance and time period. Health Net, as delegated by CHPIV, monitors effectiveness of this network to meet the needs and preferences of its membership, and to meet regulatory guidelines through annual access and availability surveys. CHPIV maintains detailed access and availability policies and procedures, which define and discuss the necessary elements for these systems across the continuum of care. Corrective actions are developed for identified performance issues per policy guidelines.

CHPIVs standards, policies, and procedures are based on contractual, state and federal regulatory, and accreditation requirements. The processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner. Description of the activities, including activities used by members that are seniors and persons with disabilities or persons with chronic conditions, and members who use Managed Medi-Cal Long-Term Supports and Services (MLTSS) in accordance with the standards set forth in 42 CFR 438.330(b)(5), designed to assure the provision of care management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services, and care management.

P. Member Experience (CAHPS)

As a new health plan, starting 2025, Health Net will monitor CHPIV's member experience throughout the year using CAHPS survey results, and monitoring member pain points including member appeals and grievances, and call center drivers. CAHPS survey results will be integrated into NCQA accreditation and various state and federal performance rating systems and reports including the following:

- DHCS Medi-Cal Managed Care Quality Improvement Reports, and
- DMHC Health Equity Report.

Improvement activities are focused on educating CAHPS stakeholders and measure owners partnering with operational areas to implement initiatives, share CAHPS best practices with provider groups, and participate in monthly Quality Governance Committee and Quality Focus Touchpoint meetings. The CAHPS Program Managers meet with several business areas including Population Health and Clinical Operations, Customer Contact Center, Appeals and Grievances, Pharmacy, Provider Network Management, Provider Engagement (Provider and PPG Facing Teams), Delegation Oversight, Sales, Marketing. Annually, the Program Managers analyze data and documents and reports to stakeholders the Integrated Member Satisfaction reports required for NCQA accreditation, to support and improve member experience.

Q. Provider Satisfaction

Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess practitioner and provider satisfaction with the network, claims, quality, utilization management, cultural, linguistic, and disability access services and other administrative services. In addition, the Provider Satisfaction Survey shall evaluate provider perspectives and concerns with the plan's language assistance program regarding:

- Coordination of appointments with an interpreter.
- Availability of an interpreter, based on the needs of the enrollee, and
- The ability of the interpreter to effectively communicate with the provider on behalf of the enrollee.

The Director of Provider Relations, in collaboration with other Health Net departments, is responsible for coordinating the provider satisfaction survey, aggregating and analyzing the findings, and reporting the results. Survey results are reviewed by the HNCS QIHEC with specific recommendations for performance improvement interventions or actions.

R. Health Education Programs

CHPIV provides health education programs, services and resources to Medi-Cal members to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health care services, and to follow self-care regimens and treatment therapies. A whole person approach is used with a focus on removing barriers to care and providing health education and guidance. Interventions are tailored to meet the member's clinical, cultural and linguistic needs.

The following interventions and resources are available at no cost to Medi-Cal members through self-referral or a referral from their primary care physician. Members and providers

may obtain more health education information by contacting the Member Services toll-free at 1-833-236-4141. Members will be directed to the appropriate service or resource based on their needs. Telephonic and website-based services are available 24/7. The Plan sends member-informing health education materials to members in their preferred threshold language or alternative format.

- Weight Management Resources: Members have access to Krames resources that encourage and promote a healthier lifestyle. These resources can be found at: Weight Management (staywellhealthlibrary.com)
- CHPIV Pregnancy Program - The pregnancy program incorporates the concepts of case management, care coordination, chronic condition management, and health promotion, teaching members how to have a healthy pregnancy and first year of life for babies. In addition, the HEd program supports the following:

    - Information about pregnancy and newborn care.
    - Community resources to assist parents in getting the things they need during pregnancy and after the baby's birth. These services include food, cribs, housing, and clothing.
    - Breastfeeding support and resources.
    - Professional medical staff who work with doctors and nurses to support members with a more difficult pregnancy.
    - Resources for members who feel down during or after their pregnancy.
    - Methods to help pregnant members quit smoking, alcohol, or drug use.

    The program also aims to reinforce the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for the baby. High-risk pregnancies receive additional care management services.
- Kick It California - Kick It California is a no-cost, statewide tobacco cessation program that addresses smoking and vaping behaviors. Services include tailored one-on-one telephonic coaching in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), a texting program in English or Spanish, a website chat function, and mobile apps on smoking and vaping. Telephonic coaching is available Monday-Friday, 7am-9pm, and Saturday, 9am-5pm (excluding holidays) by calling 1-800-300-8086. To learn more about available resources and medication options, members may call the toll-free number or visit www.kickitca.org.
- Diabetes Prevention Program - The Diabetes Prevention Program (DPP) is a 12-month long program focused on helping Medi-Cal members lower their risk for diabetes through healthy lifestyle choices and weight loss. Eligible members include any member 18 years of age and older at risk for developing type 2 diabetes.
- Teladoc Mental Health Digital Program - Eligible members age -13 and older have access to an evidence-based, self-help resource to improve their mental health. This program offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, chronic condition, pain management and many other conditions. This program is available at www.teladoc.com or through the Teladoc mobile app. Members are referred into the program via care management. Members can also self-refer into the program.
- Health Promotion Incentive Programs - The Quality Improvement/Health Education department develops, implements and evaluates incentive programs to encourage

members to receive health education and to access HEDIS related preventive health care services. CHPIV follows MMCD Policy Letter 16-005 to develop, implement and evaluate appropriate incentive programs to promote positive health behaviors among members.
- Community and Telephonic Health Education Classes - No-cost health education classes and/or webinars are available for members and the community as needed. Classes are available in English and Spanish. Topics vary and are determined by the community's needs and topic availability.

The following resources are also available to members:

- Health Education Resources - Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, weight control, diabetes, immunizations, dental care, breastfeeding, breast cancer, cervical cancer, exercise and more. These materials are available in threshold languages. Members may also access more than 4,000 topics relating to health and medication using Krames Online at www.chpiv.org.
- Health Education Programs and Services Flyer - This flyer contains information on all health education interventions offered to members and information on how to access them.
- Preventive Screening Guidelines - The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in threshold languages. They are mailed to new members and are also available on www.chpiv.org. These are available in English, Spanish and Hmong.
- Member Newsletter - CHPIV's Whole You newsletter is mailed to members once a year and covers various health topics and the most up-to-date information on health education interventions.

S. Telehealth Services

Member to Provider

On behalf of CHPIV, Health Net supports members' access to their care through telehealth programs by connecting them to licensed clinicians through leading and global providers of virtual care such as Teladoc Health. Members can schedule general medical and behavioral health virtual visits with various pediatric and adult primary care providers.

Members access the mobile apps to connect to providers anytime, anywhere by phone, video, or app. Remote consultations with doctors and mental health care professionals are provided via a secure HIPAA-compliant, videoconferencing and voice over internet protocol (VOIP) software. Medically trained, certified interpreters are available on-demand to limited English proficiency (LEP) membership across high demand and threshold languages including Spanish and American Sign Language.

The goals of the telehealth program are to:

- Enhance member and provider experiences.
- Address critical provider shortages.
- Optimize care coordination.
- Reduce overall health care costs.
- Provide equal health care access to Limited English Proficiency members.

- Provide rapid and convenient access to urgent care after hours and when members assigned PCPs are not available.
- Reduce the incidence of unnecessary emergency room utilization.

Hazel Health provides on-demand, physical health and scheduled behavioral health counseling-telehealth care at home and in schools and supports school nurses when a child has an urgent health care need. Via a computer, a child is connected to a health care professional for physical or mental health care. If a primary care physician's information is provided on the new patient questionnaire, Hazel will send follow-up records to the child's provider, improving the continuity of care. For kids needing behavioral health services, Hazel Heath can email or fax a referral form to Health Net. Health Net will refer CHPIV members who require care management to the appropriate Health Net Care Management team for follow up, as needed. Hazel Health is currently available at approximately 180 participating schools with further expansion to more sites in the coming year. Care is also available in members' home settings.

Electronic Consultation Services – Provider to Specialist

Electronic Consultation is an asynchronous, bidirectional exchange between a primary care physician (PCP) and a specialist. A PCP can consult with a specialist through a secure electronic message to initiate care for a non-urgent, non-procedural patient need. A digital referral, along with clinical information, images, lab results, and other content from the medical record, is sent to a specialist. In 70%–75% of cases, an eConsult will result in PCP management which helps prevent unnecessary/low value diagnostic testing and in-person appointments with specialists. Most eConsults are reviewed by the specialist and responded to within 3 business days, most often within 24 hours. This improves timely access for patients and removes potential geographic or language barriers that may occur during in person visits.

T. MemberConnections® Program

MemberConnections is an educational and outreach Medi-Cal program designed to help members navigate the health care system, promote preventive health practices, and connect them to health and community social services. MemberConnections representatives (MCRs) extend the reach of member engagement and Population Health Team efforts by making telephonic and home visits and providing personalized service to members. MCRs are highly trained, specialized non-clinical members of our integrated care teams. MCRs serve as a liaison/link/intermediary between the health plan and providers and members.

More specifically, MCRs:

- Conduct assessments to better understand members' needs such as the health risk screening and social determinate of health needs.
- Facilitate access to health services by scheduling medical appointments, helping members find doctors and specialists, and checking the status of referral authorizations.
- Assist with removing barriers to health care by arranging transportation and language services through the health plan vendors.
- Connect and reconnect members to clinical pharmacy, care management and chronic condition management to better manage their chronic and/or complex health conditions.

- Identify and address SDoH needs by linking members to county and community-based organizations.
- Help reduce health care costs by promoting preventive practices and educating members on how to use their benefits and appropriate utilization of health services.
- Support various outreach programs from the Health Plan. These include multiple Plan, Do, Study, Act and Performance Improvement Projects.
- Schedule and complete home visits for noncompliance members. Having “eyes on the member” to do visual assessments while in the member’s home.
- Follow-up and monitor the status of high-risk member referrals.
- Help with utilizing telehealth services.
- Completing emergency outreach during natural disasters.
  Engage members based on Population Health Prioritization Reporting and HEDIS Care Gap Reports to connect members to PCP and refer into clinical pharmacy and care management.

U. Health Management Programs

Transitional Care Services

The purpose of Transitional Care Services (TCS) is to provide a comprehensive, integrated transition process that supports members during movement between levels of care. Care transition interventions are focused on coaching the member and the member’s support system during an inpatient stay and the post discharge period to ensure timely, safe and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external resources and processes surrounding the inpatient and post discharge stay is essential in navigating the health care continuum and addressing barriers to post discharge success for the member.

The TCS process strives to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a patient-centered approach, the model incorporates three evidence-based care elements of interdisciplinary communication and collaboration, patient/participant engagement and enhanced post-acute care follow-up.

The focus of this model is based on a coaching intervention rather than a care management intervention. Under this model, the Care Transition nurse helps members and/or their primary caregiver, to support a safe discharge by:

a) Outreach to members in the hospital to enroll in TCS program and complete an inpatient discharge risk assessment and assist with scheduling post-acute follow up appts.
b) Conducting a post-acute follow-up call within 24-72 hours of discharge that actively engages the member in medication reconciliation, how to respond to medication discrepancies, ensure any post-acute services are being received, and how to utilize a personal health record (PHR).
c) Review of their disease symptoms or “red flags” that indicate a worsening condition and strategies of how to respond.

A minimum of two follow-up calls are made to members within 15 days of discharge which focus on:

- Reviewing progress toward established goals
- Discussing encounters with other health care professionals
- Reinforcement of the importance of maintaining and sharing the PHR
- Supporting the member's self-management role
- Medication reconciliation with access to pharmacist, and
- Educating the member to follow up with the PCP, and/or specialist within 30 days of discharge

After the post discharge period, the TCS staff perform a warm hand off for continued care management needs, as necessary. All assessment documents are transferred to the assuming care manager along with outstanding and/or in process issues that need additional care management intervention.

Member Impact of TCS

The TCS process has a positive impact on participating members, including outcomes such as:

- Better ability to manage member care through coaching interventions. Increasing member engagement reduces risk of adverse post discharge outcomes and/or readmissions.
- Positive experience with TCS increases member satisfaction further strengthening CHPIV's brand and market standing.
- Coaching interventions encourage active participation of the member/member's representative in the health care continuum. Members become more apt to take an assertive role in their own care.
- Problem-solving skills, proactive thinking and ability to anticipate issues.
- Ability to collaborate with clinical staff to address ongoing needs of members.
- Ability to understand psychosocial barriers and members' needs.
- Good understanding of contracted network/resources for assigned medical group including PCP, specialist physicians, radiology, laboratory services, urgent care, etc.
- Organizational and time management skills. Improved organizational and time management skills.

The TCS staff are located throughout California. They are linked through common management teams and systems. HNCS Medical Directors participate in all aspects of TCS operations.

V. Member Rights and Responsibilities

CHPIV has established a list of member rights and responsibilities that ensure members are treated with dignity and have full access to information about their care and benefits. These rights and responsibilities are reviewed and approved annually by the appropriate CHPIV staff. Members are informed of their rights and responsibilities through the member Evidence of Coverage (EOC) and other member communications.

Member rights include the right to:

- Be treated with respect, dignity, and courtesy.
- Privacy and confidentiality.

- Receive information about their health plan, its services, its doctors and other providers.
- Choose a Primary Care Physician and get an appointment within a reasonable time.
- Participate in making decisions and have a candid discussion with practitioners regarding appropriate or medically necessary treatment options.
- Decide in advance how they want to be cared for in case they have a life-threatening illness or injury.
- Voice complaints or other feedback about the Plan or the care provided without fear of losing their benefits.
- Appeal if they do not agree with a decision.
- Request a State Fair Hearing.
- Receive emergency or urgent services whenever and wherever they need it.
- Services and information in their language.
- Receive information about your rights and responsibilities.
- Make recommendations regarding the organization's members' rights and responsibilities policies.

Member responsibilities include:

- Acting courteously and respectfully toward doctors and staff and being on time for visits.
- Providing up-to-date, accurate and complete information.
- Following the doctor's advice and participating in the treatment plan.
- Using the Emergency Room only in an emergency.
- Reporting health care fraud or wrongdoing.

CHPIV has established policies that address member grievances and appeals. Grievances and appeals are resolved in a timely manner. Trends are monitored on a regular basis to assess opportunities to improve health plan processes.

W. Medical Records

CHPIV requires practitioners and providers to maintain current organized and detailed medical records. Records must be consistent with standard medical and professional practice and protected health information is handled in accordance with established policies and procedures to safeguard patient confidentiality.

CHPIV's documentation standards address format, documentation, coordination of care and preventive care and include but is not limited to the following areas: adult preventive care, pediatric preventive care and perinatal care. Standards are distributed on a regular basis and at the request of network providers.

Practitioners are required to have systems and procedures to provide consistent, confidential and comprehensive record-keeping practices.

CHPIV monitors both medical record keeping and medical record systems to assess the quality of medical record documentation and compliance with standards through medical record audits. This occurs during the HEDIS process, Department of Managed Health Care (DMHC) and CMS surveys, during routine DHCS audits, and as part of the Managed Care Quality and Monitoring Division of DHCS PCP Full Scope Facility Site and Medical Record Review process.

Annually, the data are aggregated and analyzed to evaluate effectiveness of interventions and identify opportunities for improvement. Actions are taken when compliance issues are identified, and interventions are implemented based on compliance rates established for each standard. Interventions may include sending Medical Record review Corrective Action Plans, Provider Updates, revising the Provider Operations Manual, sending educational or reference materials to practitioners or providers, creating medical record form templates.

X. Facility Site Review (FSR)/ Medical Record Review (MRR)/ Physical Accessibility Review Survey (PARS)

CHPIV delegates DHCS's required PCP Facility Site and Medical Record Reviews and Physical Accessibility Review Surveys (PARS) to HNCS. Per APL 22-017, PL 12-006, APL 15-023. HNCS collaborates with other Medi-Cal Plans to develop and maintain a standardized system-wide process for conducting reviews of Primary Care Physician (PCP) facility sites and medical records. PARS are conducted for PCPs and high volume specialists (including behavioral health), ancillary providers, Community-Based Adult Services (CBAS) providers and hospitals. Collaboration with other Medi-Cal Plans minimizes FSR and PARS duplication and supports consolidation of FSR and PARS surveys. The FSR/PARS process uses evaluation criteria and guidelines in compliance with the DHCS contractual requirements and is applicable to all Health Plans participating in the MMCD process.

The FSR team will include at least one Quality Compliance nurse, who must be a registered nurse, who has oversight responsibility for the PCP facility and medical record audit processes. This oversight process involves conducting initial evaluation, conducting annual review of activities, identifying areas for improvement, and collaboratively developing action plans to address areas of noncompliance. Results of the annual review are presented to the CHPIV Chief Medical Officer and the CHPIV QIHEC Committee.

III. Program Structure and Resources

A. QI Committees

1. Governing Body/Board of Commissioners

The CHPIV LHC Board of Commissioners is the governing body with ultimate authority and responsibility for the oversight of the CHPIV QIHEd Program. The Board of Commissioners has delegated the responsibility for development and implementation of the QIHEd Program to the CHPIV QIHEC.

Functions:

- Establish strategic direction for the Population Health Management, Utilization Management, Case Management, Credentialing, Peer Review, Health Equity, and QIHEd Program.
- Receive quarterly updates from QIHEC, and review reports from the QIHEC, delineating actions taken and performance improvements at least annually.
- Ensure the QIHEd, HE, PHM, UM, CM Programs and Work Plans are implemented effectively.

2. CHPIV Provider Advisory Committee (PAC)

The PAC is chaired by CHPIV's Chief Medical Officer. The primary responsibilities of the Provider Advisory Committee (PAC) are to advise and provide perspective to the Chief Medical Officer, CHPIV staff, and Local Health Commission regarding CHPIV policies, programs, and initiatives. Meetings are held quarterly with a minimum of three (3) meetings per year. PAC reports to the Local Health Commission, through committee minutes as well as recommendations for policy revisions and innovations. PAC consists of between eight and twelve contracted CHPIV Network Providers, Chief Medical Officer, Senior Health Services Director, and other staff may attend depending upon agenda items. Membership will reflect demographic representation within practical limits, including geographic distribution and includes Primary Care and Specialists, Behavioral Health Providers, therapists, pharmacists, Home Health agencies, and DME Providers. The specific number of participating providers shall be determined by the group annually as needed.

3. CHPIV Community Advisory Committee (CAC)

The Community Advisory Committee (CAC) is appointed by the Commission of CHPIV to advocate for CHPIV enrollees (members) by ensuring that CHPIV is responsive to members' diverse health care needs. The CAC empowers members to bring their voices to the table to ensure CHPIV is actively driving interventions and solutions to build more equitable care.

Objectives:

- Obtain local level feedback, insights, and perspectives to inform and address CHPIV operations, including quality and health equity strategy.
- Maintain a stable local presence and forum to engage and collaborate with local community partners and resources to ensure community needs are met.
- Provide perspectives on health equity and disparities, population health, children's services, and relevant plan operations and programs.
- Inform CHPIV's cultural and linguistic services program.
- Maximize member participation and involvement to solicit meaningful insights and
- perspectives to improve how CHPIV delivers services through ongoing training as well as effective meeting facilitation.
- Inform and advise CHPIV how to utilize Health Equity Improvement zones based on identified health disparities to ensure talent, resources and partnerships are aligned to improve health equity performance outcomes for members and residents of the Imperial Valley County.
- Provide forum for bidirectional communication between committee members and CHPIV leadership to inform use of community reinvestment funds.
- Assess the need for and establish Community Impact Council(s) using data, insights, and considering community and CHPIV priorities, who will collaborate with diverse community stakeholders to further drive community impact and create sustainable forums for continued work.

The CAC comprises key community Stakeholders reflective of the Medi-Cal population in the CHPIV's service area such as members (including those from hard-to-reach populations and member's with physical disabilities, and Limited English Proficient (LEP)) from diverse cultural and ethnic backgrounds, community advocates, community-based organizations and traditional and safety-net providers. The Plan will modify the CAC membership as the beneficiary population changes, and in accordance with MMCD Policy Letter 99-001 and the DHCS 2024 contract requirements.

The CAC Selection Committee shall consist of such a number of directors as the Commission shall from time to time determine. The members of the Committee shall be appointed or replaced by the Commission with or without cause. The CAC will submit regular reports of activities, findings, and formal recommendations to the QIHEC to advance the CAC purpose and objectives. CAC recommendations shall include needed interventions where applicable.

The CAC meetings are held quarterly. Detailed records of all CAC meetings, activities and recommendations for improvement activities are maintained and reviewed by staff at regular intervals, along with the Population Needs Assessment/update, and summary reports of compliance monitoring and evaluation activities. The CAC meeting minutes are publicly posted on CHPIV's website. For a complete description of CHPIV's CAC, refer to the CHPIV CAC Charter.

4. CHPIV Quality Improvement/Health Equity Committee (QIHEC)

The QIHEC is charged with monitoring medical management, health equity activities, and quality of care and services provided to members, including identifying and selecting opportunities for improvement, and monitoring and evaluating the effectiveness of interventions. The QIHEC is chaired by the Chief Medical Officer/Chief Health Equity Officer (CMO/CHEO). The QIHEC meets quarterly.

Functions:

- Review and approve the annual QIHEd and Health Equity Program Description and Work Plans.
- Report to the LHC Board of Commissioners at least annually.
- Recommend and revise, or oversee policy changes, effective QI Program operation and program achievement.
- Ensure external providers and subcontractors, who are representative of the specialties in the network {i.e. behavioral health, seniors and persons with disabilities (SPD) and members with chronic conditions} actively participate in the QI Program through planning, design, implementation, or review.
- Maintain meeting minutes for submission to the LHC Board of Commissioners and DHCS upon request; and be made publicly available on a quarterly basis.
- Review behavioral health care initiatives and outcomes, including informing the Non-Specialty Mental Health Services (NSMHS) Member and PCP Outreach & Education Plan.
- Address activities and priorities related to the QI and Health Equity Transformation Program (QIHETP).
- Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys.
- Monitor activities and evaluate the results of QI activities, institutes needed actions, and ensures follow up as appropriate.
- Analyze and evaluate the results of focused audits, studies, quality of care and safety issues and quality of service issues.
- Monitor for compliance and other quality improvement findings that identify trends and opportunities for improvement.

- Provide input and recommendations for corrective actions and monitor previously identified opportunities for improvement.
- Monitor data for opportunities to improve member and practitioner perception of satisfaction with quality of service.
- Address UM, QI, and Health Equity activities which affect implementation and effectiveness of the QI Program and interventions.
- Review, approve, evaluate, and make recommendations for physical accessibility of the practitioners and provider offices.

Representatives from CHPIV and HNCS who report up to the QIHEC include the Quality Improvement Department (including the behavioral health QI team), Health Equity and CAHPS teams, Pharmacy Department, Provider Network Management, Delegation Oversight, Customer Service Center, Credentialing, Peer Review, Appeals and Grievances, and Population Health & Clinical Operations (PHCO) which includes Utilization Management and Care Management. Refer to the CHPIV QIHEC Charter for more information on committee members, roles and functions.

CHPIV QIHEC is supported by the following subcommittees:

- Credentialing and Peer Review Committee
- Health Equity Governance Committee
- Pharmacy and Therapeutics Committee
- Delegation Oversight Committee, and
- Access and Availability Governance Committee.

5. Credentialing and Peer Review Committee

The Health Net Credentialing Committee (CC) oversees the credentialing and recredentialing process for non-delegated practitioners and providers. This process ensures that the networks of health care practitioners and providers providing professional services to CHPIV members are trained, licensed, qualified and meet criteria for participation in accordance with regulatory requirements and accrediting entity standards. The committee reviews performance data and has final decision-making authority. The Credentialing Committee has representation from primary and specialty care participating practitioners, is chaired by a Health Net Medical Director and meets monthly. Ad-hoc meetings are scheduled on an as-needed basis.

The Peer Review Committee (PRC) is an independent review body established to achieve an effective mechanism for continuous review and evaluation of the quality of care and service delivered to enrollees. This includes monitoring whether the provision and utilization of services meets professional standards of practice and care, identifying quality of care problems, addressing deficiencies, deliberating corrective actions, and when necessary, initiating remedial actions with follow up monitoring. The goal of the PRC is to ensure enrolled members receive quality care and service from network practitioners, providers, medical groups, and sub-contractors. This is accomplished through the following:

- Collection, review and interpretation of data and provider feedback that can be used in evaluating performance.
- Sharing results of analyses with practitioners and providers in a systematic and routine process.

- Prescribing and/or requesting necessary action steps for remediation of identified problems.
- Rendering ongoing observations and evaluations of issues with recommendations for quality improvement.

The PRC is a multidisciplinary committee with representation from a range of practitioners. The PRC is chaired by a Health Net Medical Director and meets at least monthly. Ad-hoc meetings are scheduled as-needed.

The following highlighted sections are applicable to the Credentialing and Peer Review Committees, not just Peer Review Committee as written: The health plan's Chief Medical Officer or designee appoints the committee chairperson, who must be an internal Medical Director. The composition of voting PRC members includes internal Medical Directors as well as community physicians; all of whom are credentialed by the health plan and are either engaged in clinical practice or belong to a medical group as a Medical Director or Administrator. All are expected to use their independent clinical judgment in assessing the appropriateness of clinical care and recommendations for corrective actions, when warranted.

On a quarterly basis, the PRC will report to the designated quality committee all cases with impact to member care and/or services. Reports include but are not limited to access to care issues and adverse events.

If at any time PRC deliberations result in recommendation for termination, suspension or altered condition of participation, the recommendation will be presented to the Credentialing Committee for acceptance, enactment of appeal rights and regulatory reporting, when applicable.

Credentialing and Peer Review Committee members and guests must sign a confidentiality and conflict of interest statement at least annually. Peer review records and proceedings are confidential and protected under applicable state and federal regulatory requirements and health plan policies for system controls.

6. Health Equity Governance Committee

The Health Equity Governance Committee supports all lines of business and addresses identified health disparities, social risks, SDoH, and community needs and makes ongoing recommendations to improve individual and community outcomes.

This Governance Committee will be led by the Health Equity Team and will include cross-functional participation. Key focus areas include:

- Identify priority areas of individual social needs and create responses and interventions accordingly.
- Select and engage with social and community partners to improve health equity and access to available community resources.
- Implement and evaluate community partnerships and sponsorships to enhance health and community resources and determine effectiveness.
- Monitor health equity programs that aim to reduce health care inequities and disparities.

- Support and strengthen equitable care through fair distribution in procedures, resources, systems, and mechanisms.
- Actively include, share, and engage diverse individuals, groups, teams, partner organizations, and community members by providing on-going opportunities and pathways for participation in decision-making processes.

7. Pharmacy and Therapeutics Committee

The Centene Pharmacy and Therapeutics Committee (P&T) is a decision-making body that meets quarterly to develop and update the company's drug formulary or drug list. The P&T Committee's primary goal is to assure continuous member access to quality-driven, rational, affordable drug benefits. The committee's members provide oversight for the development, implementation and maintenance of a regional strategy to optimize pharmacotherapy that is cost-effective for members.

The Committee membership includes Pharmacy Services pharmacists and associates and practicing pharmacists and practitioners from the provider network. A Centene medical director chairs the P&T Committee. Responsibilities include:

- Review and approve policies that outline pharmaceutical restrictions, preferences, management procedures, delineation of recommended drug list exceptions, substitution/interchange, step-therapy protocols and adoption of pharmaceutical patient safety procedures.
- Review of pharmaceutical utilization and prescribing practice patterns.
- Review, revising and adoption of the formulary on an annual basis.
- Report to the HNCS and CHPIV QIHEC at least quarterly.

8. Pharmacy Advisory Committee

The Health Net Pharmacy Advisory Committee (PAC) is responsible for oversight and communication about CHPIV's pharmaceutical program. The quarterly Committee advises on medical and pharmacy drug benefit services to ensure they are being managed effectively and efficiently, while ensuring quality care is provided to the health plan membership. Membership includes Health Net's Medical Directors or his/her designees, Centene Pharmacy Services California Pharmacy team, physicians and pharmacists, and other areas that may be impacted by pharmacy operations. The Committee functions include:

- Reviews and approves Pharmacy Policy and Procedures specific to California pharmacy operations.
- Provides input on CHPIV's Prior Authorization criteria and policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange.
- Review medical drugs authorization requirements and alignment with Pharmacy and Medical policies.
- Presents Health Plan Pharmacy Business Review and Quarterly Corporate DUR outcomes and/or clinical initiatives reporting.
- Review and approve DOFR drug categorizations.
- Reviews Corporate P&T Meeting minutes.
- Report on Annual Inter-rater Reliability (IRR) review results.

- Discuss other pharmacy related issues specific to California i.e., regulatory, Pharmacist compensation, etc.
- Discuss Pharmacy benefit options to remain competitive.
- Coordinate with various departments, including Health Care Services, Legal, Underwriting, Compliance, Finance, Program Accreditation and Provider Services Department to ensure legal and regulatory compliance.
- Report quarterly to the HNCS and CHPIV QHIEC on drug therapy management opportunities that promote the quality of care and/or services provided to members.
- Review California pharmacy operational key performance indicators to identify drug trends (financially impactful) and/or improvement areas, design action plans to improve performance, measure performance improvement, and report results to appropriate committees.

9. Delegation Oversight Committee

The Delegation Oversight Committee (DOC) is responsible for overseeing the formal process by which another entity is given the authority to perform functions on behalf of Health Net. The Delegation Oversight Committee (DOC) provides a forum for discussion of delegates performance and an opportunity to discuss significant risks with health plan leadership. The Delegation Oversight Committee meets at once a quarter with additional meetings added as needed to meet the business requirements.

Responsibilities include:

- Ensuring there is a delegation agreement between Health Net and the entity, which outlines responsibilities, activities, reporting, evaluation process, and remedies for deficiencies.
- Monitoring and evaluating a delegate's performance with regulatory and accreditation standards through ongoing monitoring and annual audits of the entities' functions.
- Taking action if oversight activities reveal deficiencies in the delegate's processes.
- Evaluating a delegate's performance prior to granting delegation.

10. Access and Availability Governance Committee

The Access & Availability Governance Committee will provide strategic direction, guidance and oversight to the Access & Availability Workgroup to meet the workgroup goals. The committee will ensure sponsorship of planned initiatives and provide management of the execution of initiatives planned by the workgroup to proactively improve access, member experience and satisfaction across all plans/lines of business and networks.

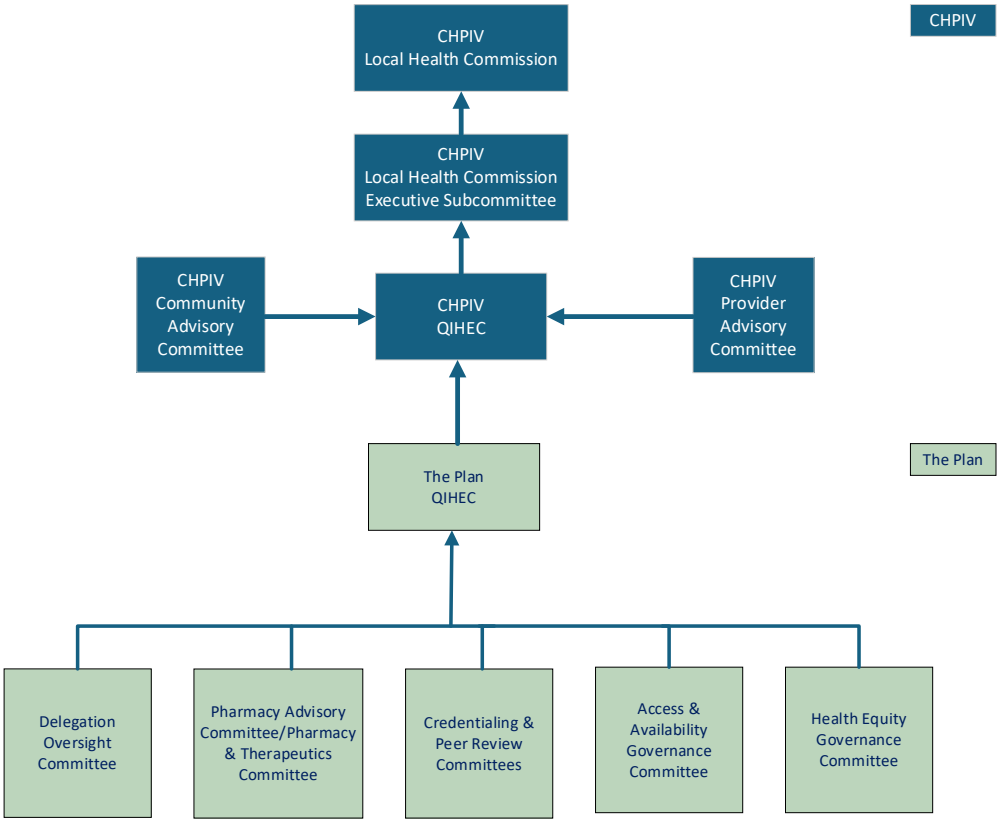
11. Other: Quality Governance Committee and Quality Focus Touchbase Meetings

Quality Governance Committee is accountable for monitoring quality improvement programs, performance and organization-wide engagement pertaining to the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) Program, HEDIS default measures and rate setting, and publicly reported report cards (e.g. NCQA Heath Plan Rankings). The overall focus of the Committee is to ensure that appropriate resources and activities are dedicated to and applied resulting in improved outcomes for members with chronic and preventive care needs.

At Quality Focus Touchbase meetings the provider engagement team strategizes with the quality improvement team on ways to improve provider/group performance on specific measures. QI shares best practices as PE shares the actions plans that they have developed with providers/groups to lead to improvements.

The CAHPS team attends the Quality Governance Committee and Quality Focus Touchbase Meetings with the Medical Affairs and Provider Engagements Teams. These meetings address all CAHPS related measures. These forums review CAHPS implementation, CAHPS results, and are an opportunity to identify areas of improvement for CAHPS member experience survey results. These meetings are cross-functional and include employees from multiple member-facing and provider-facing teams across the organization.

12. Committee Organizational Chart



B. Staff Resources and Accountability

1. CHPIV Chief Medical Officer

The CHPIV Chief Medical Officer's responsibilities include chairing the QIHEC and work group, providing oversight of QIHEd Programs, and assuring that the QIHEd, Health Equity and PHCO Programs are compatible and interface appropriately with the provider network, overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QIHEd/HE operations. This position makes recommendations to the Local Health Commission to initiate major program revisions and communicates the Local Health Commission's directives to both internal and external stakeholders. This position will be directly supported by the Senior Director of Health Services.

Health Net Department Resources

CHPIV staff, with assistance from HNCS interdisciplinary staff, contributes to the success of the CHPIV QIHEd Program. These administrative and clinical staff works with CHPIV's Chief Medical Officer to carry out QIHEd activities for CHPIV's Medi-Cal members and provider network. The resources and responsibilities of departments most involved in the QIHEd process are described below.

1. Health Net, LLC Chief Medical Officer (CMO)

This position has responsibility for the Quality and Medical Affairs Programs and must assure that the programs are compatible and interface appropriately with the provider network; oversee compliance with regulatory standards and reporting requirements; and achieve consistency in leading QI operations. This individual has direct authority over California's QI Program and staff, Medical Directors, and the Population Health program.

The Health Net LLC Chief Medical Officer (CMO) designates at least one medical director to provide clinical and administrative physician leadership to the QIHEd Program, including:

- Oversight of the development, implementation and evaluation of QI projects and population-based care programs.
- Physician leadership for NCQA and regulatory agency surveys/audits.
- Representing Health Net as the physician QI liaison to external organizations, as needed.
- Chairing the Health Net quality committees.

2. Health Net Community Solutions Chief Medical Officer/Vice President, Medical Director, Medi-Cal

The Health Net Community Solutions Chief Medical Officer/VP Medical Director, Medi-Cal reports to the Health Net LLC CMO and is responsible for the development and implementation of strategies for access to care, improved quality outcomes, regulatory compliance and cost of care management. Reporting to the HNCS CMO/VP Medical Director are Supervisory (Regional) Medical Directors. In this role, the HNCS CMO/VP Medical Director works closely with the Medical Affairs and Management teams, and cross-functional teams to create a culture of quality and accomplish the goals of the Quadruple Aim (Better Health, Better Care, Lower Cost, and Improved Provider Satisfaction).

3. **Vice President, Medical Affairs**

   The Vice President of Medical Affairs (VPMA) reports to the Health Net LLC CMO. The VPMA is responsible for clinical leadership and oversight of the following:

   - Precertification, Concurrent, and Retrospective Review
   - Appeals
   - Grievances (both Quality of Care and Potential Quality Issues)
   - Care Management, and
   - Medical Policy.

4. **Vice President of Quality Management**

   The VP of Quality Management reports directly to the Chief Medical Officer and is responsible for the overall direction and management of the QIHEd Program and staff including:

   - Organization-wide QI and HEd Program, outcomes and compliance with regulatory and accreditation bodies.
   - Successful accreditation outcomes.
   - Overall HEDIS operations and performance.
   - Credentialing, quality of care and peer review activities to ensure criteria for practitioner performance is measured and acted upon in a timely and consistent manner.
   - Health Education and Health Equity program and services are developed and implemented for all members.

5. **Behavioral Health Medical Director**

   The Behavioral Health Medical Director is involved with the behavioral health care aspects of the QI Program and participates in the HNCS QIHEC. To ensure that a close, coordinated approach to provision of behavioral health services and coordination of care with medical services is in place, the Medical Director is responsible for evaluating:

   - Continuity and coordination care between behavioral and medical health
   - Triage and referral processes, and
   - Access and availability performances.

6. **Supervisory (Regional) Medical Directors**

   The Medical Directors are licensed physicians responsible and accountable for assuring appropriate clinical relevance and focus of the Utilization Management, Care Management, Risk Adjustment, and QI Program. The Medical Directors interface with providers and individual practitioners and facilities to ensure the performance of the provider community meets established Health Net and CHPIV standards. The Medical Directors participate in HNCS QIHEC and other QI activities.

7. **Director of Quality Improvement**

   The Director of Quality Improvement report to the VP of Quality Management. One QI Director reports to the Senior Director of Quality Improvement. Responsibilities related to the

QI and HEd Program include:

- Overall management of the QIHEd Program.
- Resolve barriers that prevent appropriate monitoring of quality of care and quality of services.
- Assure implementation of quality improvement and wellness activities.
- Review reports, identify issues, formulate policies and procedures and make recommendations to the QI committees.
- Provide consultation to Quality Management associates.
- Maintain NCQA accreditation, QI and HEd compliance.
- Direct and lead a cross-functional Health Net team, identifying and ensuring action is taken on priorities, leveraging relationships and leading to ensure appropriate and substantive interventions among leaders.
- Continuously assess the data and information available on performance measures, identify trends and risk areas, and then create a platform for change amongst the key CHPIV stakeholders.
- Lead reporting and enterprise communication processes to share gaps and opportunities for improvement.
- Manage vendor relationships as necessary to support the processes to improve HEDIS and Medi-Cal Managed Care Accountability Set (MCAS) performance.
- Overall direction and management of the health education and wellness related programs including health disparities reduction efforts.
- Leads national health education/promotion projects to operationalize regulatory requirements, establish best practices, design policies, establish standards, and ensure implementation and compliance.
- Review reports, identify issues, and make recommendations to the QI committees. Direct and oversee department-led interventions and programs that address CAHPS measures and identify and ensure action is taken on priorities.

8. Senior Director, Reporting and Business Analysis

The Senior Director of Reporting and Business Analysis reports to the VP of Quality Management and oversees a team of data analysts, project managers and support staff. Responsibilities related to the QI Program include:

- Direct management oversight for business process initiatives and optimize quality and efficiency in support of HEDIS objectives.
- Develop HEDIS organizational structure and resources allocation to assure the most efficient and successful HEDIS operation results.
- Building adequate resources within HEDIS Operations who are accountable for determining, operation and maintaining appropriate HEDIS reporting and operating systems.
- Serve as liaison and subject matter expert for the HEDIS business areas, providing assistance and direction for business processes to ensure timelines and desired business outcomes are realized.

9. Director of Quality Improvement Data Analysis

The Director of Data Analysis reports to the Sr. Director, Reporting and Business Analysis. Responsibilities related to the QI Program include:

- Assure identification of opportunities for quality improvement activities, related to achieving quality outcomes (e.g., Stars, clinical metrics, NCQA accreditation, member satisfaction).
- Review reports and guide the analytic approach across all lines of business and make recommendations to QI Committees.
- Assure implementation of quality improvement metrics and outcome measures.
- Ensure delivery of in-depth analysis to evaluate quality of care and service, member satisfaction and overall CHPIV performance to identify opportunities for improvement.
- Continuously assess the data and information available on performance measures, identify trends and risk areas, and then create a platform for change amongst the key CHPIV stakeholders.
- Lead reporting and enterprise communication processes to share gaps and opportunities for improvement.
- Ensure collaboration with HEDIS staff to identify areas of opportunity.
- Develop tools to track progress toward established goals and identify areas of opportunity.
- Provide feedback on quality outcomes and progress to Corporate and Market leadership.
- Identify data to be collected for QI initiatives, ensuring sound methodology and data collection for use in applicable outcome studies/evaluations.

10. Director of Clinical Services

The Director of Clinical Services reports to the VP of Quality Management. Responsibilities related to the QI Program include:

- Assure the Credentialing Department conducts credentialing/recredentialing activities in accordance with Health Net and CHPIV standards, state and federal regulatory requirements, and accrediting entity standards.
- Oversee Peer Review and Credentialing activities including the investigation of track and trend issues, identification of adverse action events, and presentation of quality issues to the Peer Review or Credentialing Committee.
- Oversee the Clinical Quality of Care (QOC)/Potential Quality Issues (PQI) Department is meeting state and federal compliance standards.
- Oversee facility site and medical record reviews activities, including identifying deficiencies for PCPs meeting DHCS standards, corrective action plans, and physical accessibility review surveys for both primary care practitioners and high-volume specialty providers, including behavioral health, ancillary and CBAS centers.

The Director of Clinical Services directs the clinical quality of care and the potential quality issues with guidance from the Senior Medical Director. Potential quality of care issues are reviewed by a Health Net Medical Director and based on findings, are given a severity level, and if indicated, submitted to the Peer Review Committee (PRC) for appropriate resolution. Quarterly, an aggregate report of the number, severity, actions taken, adverse events and trends noted are reported to the HNCS QIHEC.

The Credentialing Department is responsible for implementation of the credentialing program and the credentialing/recredentialing of health care practitioners and providers in accordance with Health Net and CHPIV standards for participation requirements, state and federal regulatory requirements, and accrediting entity standards. The department is also responsible for the credentialing adverse actions process, as well as peer review activities and committees.

11. Quality Improvement Senior Managers/Managers

Health Net Quality Improvement Senior Managers/Managers report to the Senior Director/Director of Quality Improvement. Managers oversee and manage the functions of the Quality Improvement Program and Health Education System, including HEDIS reporting, quality improvement and health education activities and other regulatory and compliance reporting. Responsibilities related to the QI Program include:

- Provide support to staff and facilitate daily quality improvement (QI) and health education functions through effective communication with departments and staff.
- Review and analyze reports, records, and directives for quality improvement and health education programs and services.
- Manage, oversee, and monitor all assigned quality improvement and health education programs, services, and initiatives.
- Confer with staff to obtain necessary data for planning work activities, including HEDIS reporting.
- Verify data submission compliance with government program requirements and ensure adherence with state, federal and certification requirements.
- Prepare and oversee reports and records on work activities for management.
- Evaluate and improve current procedures and practices and to meet required standards.
- Manage delegate vendor oversight and corrective action plans as indicated.
- Monitor and analyze costs and assist with budget preparation.
- Communicate (or be a point person for) the respective product line goals and objectives.
- Support Programs, Owners, and Drivers (POD) results and productivity by communicating expectations and monitoring staff deliverables and participation.
- Provide manager oversight for respective PODs, including the development and implementation of strategies to drive performance improvement and promotion of programs.
- Maintain and address staffing and personnel needs.
- Oversees the completion of work plans, program descriptions, work plan evaluations, annual and semi-annual Member Incentive reports, policies & procedures.
- Provide oversight and management of rating systems such as the Medi-Cal Managed Care Accountability Set (MCAS).

12. Health Equity Manager

The Health Equity Manager leads the planning and administration of health equity and cultural and linguistic programs/services and co-leads NCQA Health Equity Accreditation Plus program for Medi-Cal line of business. Responsibilities for cultural and linguistic (C&L)/Health Equity include the following: planning and administration of C&L/Health Equity services and mandated requirements statewide; designing policies, establishing standards and ensuring implementation and compliance for Health Net to meet Department of Health Services, Centers for Medicare and Medicaid, National Committee on Quality Assurance,

and C&L/Health Equity contractual/accreditation requirements; providing leadership and management for Health Equity staff; and representing the health plan at external regulator and accreditation meetings and taskforces. The Health Equity Manager also educates department leads on proposed and/or newly enacted legislation, oversees the delivery of culturally and linguistically appropriate services at all plan member points of contact, and ensures that regulatory and accreditation requirements are met.

The following Health Equity Department's goals are implemented through four core competencies – language services, cultural competency, health literacy and health disparities reduction:

- Ensure language services meet regulatory requirements and achieve metric goals.
- Achieve appropriate reading grade level requirements and cultural appropriateness at market and product levels.
- Complete staff and provider trainings for required topics.
- Address health disparities through targeted cross-collaborative projects.
- Implement social needs assistance strategies with integrated approaches for mitigating social risks.

13. Health Education Lead

The Health Education Lead has a Master's degree in Public Health (MPH). The lead is responsible for the oversight, planning, coordination, and administration of health education programs and services for CHPIV members. The lead is also responsible for:

- Overseeing the implementation and evaluation of the department's health education interventions and policies.
- Participating (or delegating participation) in community partnerships with local and state health departments.
- Budgeting and overseeing the department's operations.

14. Quality Analytics Program Managers

Quality Analytics Program Managers are responsible for identifying, managing and tracking clinical, quality, correct coding, documentation and data submission projects that advance the objectives of CHPIV's strategic goals.

Responsibilities include:

- Working across functional teams to develop performance trackers and tools as needed to meet national performance targets and drive quality improvement.
- Addressing the DHCS Corrective Action Plan (Medi-Cal) by providing insight through statistical analysis of utilization and member data to identify opportunity areas that inform QI intervention.
- Facilitating the development of internal and external reports and the delivery of data as needed to support and monitor the action plans to accomplish the Quadruple Aim:
  a) to improve member experience
  b) to improve the quality of care
  c) to reduce health care costs, and
  d) to improve the provider experience.

15. Quality Improvement Analysts

The Quality Improvement Analysts reporting under the Director of QI Data Analysis conduct in-depth analysis to evaluate quality of care and service, member and provider satisfaction and overall CHPIV performance to identify strategic opportunities for improvement.

Responsibilities include:

- Conduct deep dive strategic analyses to identify provider performance deficiencies and population vulnerabilities to target QI interventions.
- Review and assist in study design/methodology and provide data to be utilized for QI studies to meet regulatory requirements.
- Review and analyze the study findings and recommend corrective actions and next steps.
- Establish and implement programs and initiatives to meet NCQA and regulatory requirements.
- Continuously assess the data and information available on plan performance, to identify trends and risk areas.
- Provide support, guidance and collaboration to stakeholders in other Health Net Departments to assure implementation, analysis and follow-up of CHPIV activities.
- Develop tools to track progress toward established goals and identify areas of opportunity.

16. Quality Management Program Managers

The Quality Management Program Managers reporting to the Quality Improvement Directors/Senior Director/Sr. Managers are responsible for setting the tactical priorities for HEDIS performance improvement and managing projects across lines of business that advance the objectives of CHPIV's strategic goals.

Responsibilities include:

- Serving as functional leaders across lines of business for targeted areas, including:
  - Child/adolescent health
  - Behavioral health
  - Health education promotion strategies
  - Oversight of quality contractual requirements, and fostering statewide partnerships
  - Member engagement strategy
  - CAHPS strategy support, and
  - Provider engagement strategy.
- Setting tactical priorities based on data, provider partners and membership, oversight of quality contractual requirements, and fostering statewide partnerships..
- Managing programs and evaluating effectiveness to achieve the targeted benchmarks and above.
- Assessing risks and monitoring performance of prior year's lower priority measures, elevating risk as needed, and setting as new tactical priority.
- Evaluating monthly HEDIS data, where applicable, to identify and/or track targeted population's progress.
- Supporting statewide program implementation and evaluation locally.

17. Quality Improvement Project Managers

Quality Improvement Project Managers implement QI Direct Care and Supportive Services initiatives and design associated studies to evaluate initiative effectiveness for Imperial County. They report to the Senior QI Manager, Manager of Program Accreditation, or QI Director.

Responsibilities include:

- Design and implement statewide programs that address member barriers and support care gap closures by providing direct care to members through innovative delivery methods.
- Develop strategies to effectively communicate to members through diverse methods and ensure all communication tools are accurate and relevant.
- Deploy methods to drive behavior change by encouraging members to seek care (i.e., member incentives, etc.).
- Design and implement evaluations to determine the most efficient and effective methods for HEDIS performance improvement.
- Tackle and monitor all statewide programs to report progress, address issues and adapt programs to meet target population needs.
- Scale up effective programs from Regional Teams, and deploy programs, trainings, and resources based on Imperial Region priorities.

18. Sr. Quality Improvement Specialists

Senior Quality Improvement Specialists implement quality improvement initiatives and studies for CHPIV through multi-disciplinary workgroups designed to address clinical and service issues to meet all regulatory and accreditation requirements. They report to the QI Senior Managers or QI Directors.

Responsibilities include:

- Conduct the evaluation and review of the effectiveness of the QI Program and prepare documents for submission to the QI Committees, Executive Management Team, and the Board of Directors.
- Provide support, guidance and collaboration to Health Net departments to assure implementation, analysis and follow-up of CHPIV activities per the QI Work Plan.
- Review and/or revise policies and procedures on an annual basis, or as necessary.
- Identify data to be collected for selected studies and review format and methodology for appropriateness. Review and analyze the findings and recommend corrective actions and re-measurement as applicable.
- Establish and implement programs and initiatives to meet NCQA and regulatory body requirements.
- Development and implementation of member and provider interventions to improve HEDIS outcomes.
- Conduct deep dive analysis to identify provider group performance deficiencies and population vulnerabilities to target QI interventions.

19. Compliance Specialists

The Compliance Specialists report to the Manager of Accreditation and provide the following key deliverables and support to the overall QI Program:

- Support committee maintenance operations as needed.
- Monitor, report and execute necessary changes for programs and initiatives to meet NCQA and regulatory body requirements.
- Review and/or revise policies and procedures on an annual basis, or as necessary.
- Ensure all audit deliverables are prepared and maintained, including resolution of corrective action plans.

20. Manager of Program Accreditation

The Manager of Program Accreditation reports to the Senior Director of Quality Improvement. Responsibilities related to the QI Program include:

- Ensuring maintenance of Health Plan Accreditation, Health Equity Accreditation/Health Equity Accreditation Plus, and maintain compliance with additional required NCQA accreditation programs.
- Coordination of the HNCS Quality Improvement/Health Equity Committee.
- Ensure collaboration between Quality, Provider Engagement, and Medical Affairs to increase HEDIS rates.
- Review reports, identify issues, and make recommendations to the QI committees.
- Organize activities and provide consultation to Quality Management associates and other business units on areas related to accreditation.

21. Sr. Health Education Specialists/Health Educators/ Program Manager II

Health Education staff hold Bachelor and Master degrees in health education, public health, health science, kinesiology, nursing, and nutrition. They are responsible for the development, promotion, and implementation of member health communications, health education programs, and community-based partnerships benefiting members. These programs and services reach all member households.

Health Education staff are responsible for numerous projects and initiatives within the focus of member wellness, disease prevention and member retention. Projects include, but are not limited to, managing member incentive programs, digital and coaching wellness program, and diabetes prevention programs. Staff oversee the revision of existing wellness programs, updating health education literature, and the design and development of new programs as needed. The staff is also responsible for the regulatory review and compliance of health education and wellness collateral and member communication related to Health Net's health education and wellness programs for Commercial, Marketplace, and Medicare lines of business.

The Program Manager II (Training Specialist) is responsible for managing quality improvement initiatives, overseeing training programs, and supporting health education activities while ensuring compliance with regulatory requirements. This role leverages expertise in Quality Improvement, Health Education, and Wellness to develop and deliver training materials in collaboration with subject matter experts (SMEs), supporting both

internal teams and external stakeholders. This role maintains training schedules, coordinates external training sessions, and assesses training effectiveness, providing recommendations to enhance programs. Regulatory responsibilities include leading SNP compliance by preparing and submitting reports such as the SNP Models of Care and annual evaluations to CMS and DHCS. By supporting the development of QI documentation, pulling QITS tracker data, and ensuring the timely completion of projects, the Program Manager II (Training Specialist) plays a critical role in advancing organizational quality improvement and training objectives.

The Program Manager II (QI Regulatory) is responsible for managing quality improvement initiatives while ensuring compliance with regulatory requirements. Regulatory responsibilities include leading DHCS Performance Improvement Projects (PIP), Plan-Do-Study-Act (PDSA), A-3 Lean Reports, Transformational PIPs, Comprehensive Quality Improvement Projects. The Program Manger supports routine (monthly/quarterly) assessment of programs, including the development of evaluations plans, drafting criteria (in collaboration with the Program Manger III) to assess program effectiveness and prioritizing programs. The Program Manager also leads workgroups related to the regulatory deliverables with internal and external stakeholders and community partners. This is inclusive of the following coordination: Facilitation of meetings, agenda development, dissemination of action items, and monitoring and reporting progress. Program Managers also manage individual vendors to ensure compliance with the scope of work and timely, accurate invoice submissions. The Program Manger II (QI Regulatory) role is crucial to ensuring the organization meets the regulatory deliverables mandated by each governing body.

22. Quality Improvement Specialists/Quality Program Strategist

The Quality Improvement Specialist and Quality Program Strategist roles support the implementation of quality improvement initiatives, regulatory compliance, and strategic program management across lines of business to enhance member outcomes and provider performance. Responsibilities include:

- Implement and support quality improvement initiatives and programs across lines of business, ensuring alignment with organizational goals and regulatory requirements.
- Abstract, analyze, and manage data for quality reporting, decision-making, and trend analysis. Prepare ad-hoc and required reports to support project and program objectives.
- Track and coordinate projects to ensure timely execution, compliance, and alignment with specified objectives. Serve as the project liaison between teams to ensure efficient delivery of outcomes.
- Facilitate the development and maintenance of policies, procedures, and materials to align with best practices and regulatory requirements. Support audits and ensure corrective action plans for identified deficiencies are implemented promptly.
- Support the Quality EDGE program through data entry, tracking reports, and assisting provider-facing teams with funding requests.
- Prepare quarterly and board-level committee slides, track updates for workplans and evaluations, and support other activities as needed.
- Prepare for audits, maintain accurate records, and coordinate team input for policies, procedures, and desktop updates to meet compliance standards.

C. Other Departments

1. Utilization Management/Population Health & Clinical Operations (PHCO)

CHPIV's Chief Medical Officer is ultimately responsible for the design, implementation and monitoring of the effectiveness of utilization and PHCO programs. A systematic approach is used by CHPIV with the assistance of HNCS staff, to identify and manage members who are currently accessing inpatient or ambulatory health care services. HNCS Medical Affairs and PHCO Departments partner with contracted practitioners and member/family and/or caregivers to monitor, to evaluate and to facilitate continuity and coordination of care among CHPIV's members. PHCO staff interfaces with the QI staff in development, management and assessment of programs designed to improve the health of CHPIV members. HNCS UM Department prepares and presents reports to CHPIV's QIHEC at each meeting and presents a semi-annual and annual report on the UM Workplan. HNCS seeks input from the CHPIV QIHEC and Local Health Commission prior to preparing the annual Work Plan. The CHPIV Health Services Division performs regular audits of Health Net's UM and PHCO operations, policies, and processes.

2. Operations

Health Plan Operations works in conjunction with Population Health and Clinical Operations for the monitoring and oversight of clinical performance metrics and operations for programs such as the Nurse Advice Line, SPD HRA, in-app two-way communication program, telemedicine, surgery decision support program, behavior health services for members, and the specialty UM/prior authorization vendor for musculoskeletal and other select procedures.

3. Credentialing/Recredentialing

CHPIV delegates credentialing/recredentialing of practitioners and organizational providers to HNCS but retains oversight and ultimate authority for such function.

4. Appeals and Grievances

The Appeals and Grievance Department is responsible for conducting full investigation and fair review of all member concerns and/or reconsideration requests. This includes reasonable efforts to gather all information needed to make accurate decisions and provide the member with a resolution in writing within applicable regulatory timeframes. If an appeal has been upheld by the plan, the member is provided their next level of appeal rights which provides the member an independent third-party review and the option to request a State Fair Hearing.

Appeals and grievances are monitored and trended to identify opportunities for improvements in service and quality of care. The Appeals and Grievance Department will provide monthly operational and quarterly reporting to CHPIV QIHEC. These reports are to ensure and allow the departments the ability to review, act and follow-up on services, quality events or trends that are significant at the practitioner, provider, or plan level. Initiatives are put in place, as needed to address any identified deficiencies.

5. Customer Contact Centers

The Plan's Customer Contact Centers, operated by HNCS on CHPIV's behalf, are responsible for addressing telephone inquiries from members and practitioners. Based on established criteria, the Customer Contact Center refers specific appeals and grievances and expedited requests to appropriate CHPIV and HNCS staff for focused evaluation and follow-up for any quality of care or service issues. Quarterly reports of trended member/practitioner service-related issues are compiled and reviewed for action. The analysis of these reports comprises one of the data sources utilized by CHPIV's Chief Medical Officer to directly identify and/or confirm opportunities for improvement.

6. Provider Network Management

CHPIV delegates provider network management to HNCS. HNCS Provider Network Management staff initiates and directs efforts to recruit and expand hospital, practitioner and ancillary provider networks to serve CHPIV members. The Provider Network Management staff liaisons also collaborate with the hospitals, practitioners and other providers for the resolution of contractual issues related to the terms and conditions and/or payment rate(s) for certain services.

7. Provider Engagement and Provider Performance & Analytics

The Provider Engagement and Provider Performance & Analytics departments provides oversight and capabilities in support of improving and maintaining performance with providers and their membership across all lines of business. Collaboration between the departments involve the Provider Relations, Practice Transformation, Encounters, RAF, and Data Analytics and Solutions teams. The Provider Engagement and Provider Performance & Analytics departments' success is dependent on both "internal" and "external" alignment to improve practitioner and provider performance and satisfaction.

Key responsibilities of the Provider Engagement and Provider Performance & Analytics departments include:

- Monitor and maintain and/or improved provider compliance (HEDIS, CAHPS, practitioner/provider satisfaction, UM metrics, RAF and encounter submissions) through provider outreach, training and education.
- Oversee and evaluate provider effectiveness.
- Assure business capabilities meet and support provider and member needs.
- Improve technical support, bi-directional data exchange, and communication channels or methodologies.
- Identify trends, issues, and opportunities to form and adopt best practices and meet or exceed performance targets.
- Engage and collaborate with targeted practitioners and providers through performance improvement projects.
- Collaborate with practitioners, providers and cross-functional departments to build and align incentives based on performance goals.

8. Delegation Oversight

CHPIV staff is responsible for the development, implementation, monitoring, and auditing of the delegation program for functions (e.g., utilization management, credentialing, peer review, claims and claims administration, etc.) delegated to HNCS and other entities as

specified in written agreements between CHPIV and the entities. CHPIV staff maintains responsibility for the implementation and monitoring of corrective action plans resulting from oversight recommendations.

9. Vendor Management Office (VMO)

The core responsibilities of the VMO are oversight, monitoring, and auditing of vendor delegates. Regular Joint Oversight Committees (JOCs) are led by the VMO in which performance metrics, member experience, complaints and grievances and the status of corrective actions are reviewed. Corrective actions are issued for non-compliance with service level requirements or for audit findings and are tracked through remediation.

10. Pharmacy Services

CHPIV is responsible for managing the pharmaceutical benefits for Physician Administered drugs under the medical benefit. The self-administered drug benefit is carved out and managed by DHCS under the program known as Medi-Cal RX. Information regarding Medi-Cal RX can be found at https://medi-calrx.dhcs.ca.gov/home.

HNCS will assist CHPIV in the establishment and maintenance of the Pharmacy Medical Drug Benefit. This includes the implementation of policies and procedures ensuring the safety, quality and appropriate use and delivery of drug products, as well as review of requests for pre-service, pre-authorized urgent and prior authorization of medical benefit drugs. Analysis includes drug utilization patterns, pharmacy service indicators and cost-effectiveness monitoring of the pharmaceutical care and services provided to CHPIV members. Pharmaceutical services reports shall be made to the CHPIV QIHEC on a quarterly basis.

11. HEDIS Management and Clinical Reporting

HNCS provides CHPIV with the HEDIS Management and Clinical Reporting Team which is responsible for HEDIS data collection and reporting. This team works collaboratively with CHPIV staff to collect and report data.

12. Public Programs

The Public Programs department monitors and acts as a resource for the LTSS {CBAS, MSSP, in-home support services (IHSS), and LTC} services for members. The department is engaged in the following activities:

- Support access to care initiatives through member outreach, coordination of care, and nursing home transitions.
- Early identification and referral to California Children's Services (CCS), and outreach to members aging out of program twelve (12) months before their twenty-first birthday to avoid interruption in care.
- Referral/connection to carved out Medi-Cal benefits and providers.

13. Program Accreditation

The Program Accreditation (PA) team supports and promotes activities to assess and monitor CHPIV ongoing compliance with requirements of accrediting bodies (NCQA). Responsibilities include managing the accreditation timelines, coordination and submission of documents and implementation of any identified actions based on survey outcomes. PA works with CHPIV staff to ensure all aspects of survey submission. The PA team also manages collaboration between Quality, Provider Engagement, and Medical Affairs to increase HEDIS rates as it pertains to Quality Evaluating Data to Generate Excellence (EDGE) efforts.

14. Additional Resources

Additional resources available to the QI Program:

- Marketing/Sales
- Compliance
- Privacy
- Legal
- Web Development
- Strategic Sourcing and Procurement
- Claims/Encounters
- Provider Communications, and
- Member Communications.

The **Management Information Systems (MIS)** supporting the QI Program allows key personnel the necessary access and ability to manage the data required to support the measurement aspects of the QI activities. Computer systems used by the Plan to support Quality Management includes:

- **Centelligence™**: A comprehensive family of integrated decision support and health care informatics solutions. The Centelligence™ platform integrates data from internal and external sources, producing actionable information: everything from care gap and wellness alerts to key performance indicator (KPI) dashboards, provider clinical profiling analyses, population level health risk stratifications, and over 12,000 unique operational and state compliance reports.
- **Centelligence™ Enterprise Data Warehouse (EDW)**: Supporting both Insight and Foresight, EDW receives, integrates, and continually analyzes an enormous amount of transactional data, such as medical, behavioral, and pharmacy claims, lab test results, health assessments, service authorizations, and enrollee and provider information as required for QI Programs.

  The EDW, powered by Teradata Extreme Data Appliance high performance technology, is the central hub for service information that allows collection, integration, and reporting of clinical claim/encounter data (medical, behavioral health, laboratory, pharmacy, and vision); financial information; medical management information (referrals, authorizations, health management); member information (current and historical eligibility and eligibility group, demographics, PCP assignment, member outreach); and provider information (participation status, specialty, demographics) as required by the QI Program. The Plan captures and utilizes data from both internal and subcontractor sources for administration, management and other reporting requirements and can also submit and receive data as well as interface with other systems, as necessary.

- **Statistical Analysis Software**: SAS is an integrated software suite for advanced analytics, business intelligence, data management, and predictive analytics. You can use SAS software through both a graphical interface and the SAS programming language, or Base SAS. R is a programming language and software environment for statistical computing and graphics. Quality improvement uses a combination of SAS and R for all lines of business to extract data, conduct barrier analysis, and conduct statistical analysis (Modeling and statistical testing to assess outcomes).
- **R**: an open-source software environment for statistical computing and graphics. QI utilizes the R-Shiny package within R to build and display interactive dashboards.
- **MicroStrategy**: MicroStrategy is an enterprise business intelligence (BI) application software vendor. The MicroStrategy platform supports interactive dashboards, scorecards, highly formatted reports, ad hoc query, thresholds and alerts, and automated report distribution.
- **Cotiviti** (Verscend): A software system used to monitor, profile and report on the treatment of specific episodes, care quality and care delivery patterns. Cotiviti is an NCQA-certified software; its primary use is for the purpose of building and tabulating HEDIS performance measures. Enables the Plan to integrate claims, member, provider and supplemental data into a single repository, by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information.
- **Cozeva**: A value-based NCQA-certified care operating system with reporting and analytics functionality, offers up-to-date information on quality and risk measures to plan providers. Cozeva gives providers visibility to provider-level incentives, and supports supplemental data submissions, data integrations with EMRs, and biweekly data syncs to CAIR and various EHR systems. Provider groups have the ability to track and trend performance of their providers to better monitor, understand, and take action on performance gaps through customizable dashboards.
- **Tableau**: Tableau is a data visualization tool which connects easily to several data sources and allows for rapid insight by transforming data into dashboards and are also interactive. Quality uses this software for plotting data on maps and displaying outcomes through dash-boarding.
- **Quest Analytics**: Quest analytics allows geo-mapping to conduct analysis on provider and facility access and compliance for our membership.
- **TruCare**: Enrollee-centric health management platform for collaborative care coordination, and care, behavioral health, disabling condition, and utilization management. Integrated with Centelligence™ for access to supporting clinical data, TruCare allows Population Health and Clinical Operations staff to capture utilization, care and population-based chronic condition management data; proactively identify, stratify, and monitor high-risk enrollees; consistently determine appropriate levels of care through integration with InterQual Criteria and capture the impact of our programs and interventions.
- **OMNI**: The call center application with guided workflows and business process drivers that allow the business better flexibility and integration with other systems and with changing environments. OMNI application is used to research, record and share information between providers and members.
- **PRIME**: A system application used by employees to handle complaints, grievances and appeals. PRIME includes business process management features that integrate with upstream applications, including Membership, Provider Authorizations and OMNI.

IV. QI Program Activities

QI Program activities are selected based on their relevance to CHPIV's membership, the ability to affect a significant portion of the population or the population at-risk and their potential impact on high-volume, high-risk or high-cost conditions or services. Morbidity, mortality and vulnerable groups with special needs are considered in the selection process as well as race, ethnicity, and language disparities.

CHPIV fosters a multi-disciplinary approach to the quality improvement process and involves all functional areas with direct impact on quality and safety of care and service. Activities involve Health Net departments and collaborations with network providers, community entities including public health, quality improvement organization and behavioral health (see QIHEd Work Plan for details of performance improvement goals, objectives, and activities). The QI Program uses PDSA cycles as one method for monitoring quality improvement activities.

A. Projects, Surveys and Audits

Issues/topics are selected based on identified opportunities for improvement through member and provider input, nationally and regionally identified or mandated projects, HEDIS, CAHPS/ECHO measurement and participation in regional and national coalitions. This includes:

- Quality Improvement Activities (QIAs), Quality Improvement Projects (QIPs), and Performance Improvement Projects (PIPs) to improve an aspect of clinical care or service. These may include activities to improve HEDIS and/or CAHPS indicators, activities for disease conditions, or other identified areas for improvement by regulators such as DHCS.
- Data collection improvement projects: Includes deploying contracts with health information exchanges and vendors that receive or process claims, encounters, member demographics or clinical data to improve efficiency of operations.
- Community support.
- Behavioral health projects to monitor behavioral health care using data from HEDIS indicators, and member, practitioner and provider surveys.
- Audits, both internal and external reviews, to ensure that CHPIV maintains compliance with all regulatory and accreditation requirements.
- Surveys including HEDIS, CAHPS/ECHO, health risk assessments, and provider satisfaction surveys, full scope facility site review surveys, and physical accessibility review surveys.
- Mobile mammography units to improve access to services to complete breast cancer screenings.
- Provider resources including report cards, gap reports, provider portal, educational resources and trainings.
- Pediatric and Maternal Health Programs promoting provider and member engagement with projects to improve immunizations, well-child visits, prenatal and postpartum care, lead screenings, and maternal health equity. Providers are supported to engage with immunization registries and Vaccines for Children Program.
- Engagement to improve hospital quality, including collaboration with leading external stakeholders to address priority metrics, such as patient safety and maternal health indicators.

B. Incentive Programs

CHPIV rewards targeted members for healthy behaviors and collaborates with providers to build performance-based incentive programs. Development and implementation of incentives are aligned with CHPIV's provider partnership, and strategies.

Member:

- Tailored member incentives offered to target the Medi-Cal population to assist in closing care gaps for priority HEDIS measures including breast cancer screening, cervical cancer screening, diabetes management, well-child visits, and childhood immunizations.

Provider:

- Tailored provider and PPG incentive programs for Medi-Cal providers for HEDIS outcomes and encounter submissions.

V. Provider Communications

Effective communication with network providers and subcontractors is crucial in advancing Community Health Plan of Imperial Valley's quality improvement initiatives, studies, and fulfilling contractual obligations. Engagement with the Quality Improvement Health Education (QIHEd) Program is facilitated through various methods, including:

- Practitioner and provider office visits: Conducted by designated members to ensure direct and personalized communication.
- Online training and educational webinars: These resources provide continuous learning opportunities and keep participants informed about the latest guidelines and best practices.
- Joint Operation Meetings (JOMs) and work groups: These collaborative forums foster active participation and dialogue, ensuring alignment with quality improvement goals.

This structured approach ensures that all participants are well-informed and actively contributing to Community Health Plan of Imperial Valley's mission of enhancing health care quality and efficiency.

To keep health care providers informed about QIHEd and Wellness program activities, modifications and outcomes, as well as available quality resources and programs, several key methods are utilized. The resources described below can be accessed through the Provider Library at providerlibrary.healthnetcalifornia.com or on other provider resource pages available on the Health Net website at healthnet.com. Additionally, CHPIV's provider resource webpage redirects providers to the Health Net Provider Library.

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Provider Resources – Community Health Plan of Imperial County

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Available Resources:

- Provider Operations Manuals and Medi-Cal Operations Guides: Comprehensive manuals and guides outlining the operational policies and procedures necessary for providers to effectively deliver services.
- Provider Updates and Letters: Regular updates and communications sent to providers to keep them informed about important changes and developments.
- Provider Newsletters: Quarterly newsletters offering insights and updates about various health programs, initiatives, engagement in our communities, and best practices.

- Forms and Reference Documents: Essential forms and reference materials needed for administrative and operational purposes.
- Educational Materials and Resources: Resources aimed at enhancing provider knowledge and skills related to QIHEd and Wellness programs.

Communication Channels:

Provider updates, letters, and educational materials and resources are distributed via multiple channels including fax, mail and email. Additionally, these communications and materials are available in the Provider Library at providerlibrary.healthnetcalifornia.com under the "Updates and Letters" section, or on other provider resource pages on the Health Net provider website at healthnet.com. Additionally, CHPIV's provider resource webpage redirects providers to the Health Net Provider Library.

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Provider Resources – Community Health Plan of Imperial County

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VI. Corrective Actions

CHPIV takes timely and appropriate action to correct any significant or systemic problems identified through audits, internal reports, complaints, appeals, grievances, and delegation oversight activities.

VII. Program Evaluation and Work Plan

A. Review and Oversight

The Local Health Commission is responsible for QI Program and annually receives reviews and approves the CHPIV QIHEd Program Description, Work Plan and Program Evaluation. The CHPIV QIHEC submits regular reports to the Commission on quality findings related to monitoring and quality issues identified and activities initiated.

B. Annual QIHEd Evaluation

The evaluation of the QIHEd Program and Work Plan is based on the results of a systematic monitoring and assessment of QIHEd efforts. It includes a summary of completed and ongoing QIHEd activities, trending of measures to assess performance (quality of service and clinical care, and safety of clinical care), analysis of the results of QIHEd initiatives (including barriers), and evaluation of the overall effectiveness of the QIHEd program, which is conducted during the year. The process identifies program strengths and limitations, improvement opportunities and unfinished business. The QIHEd Evaluation assesses the adequacy of resource allocations needed to plan and implement the QI activities and programs for the upcoming year. The annual QIHEd Program Evaluation and Work plan are reviewed and approved by CHPIV QIHEC during the first quarter each year.

C. Annual QIHEd Work Plan

The work plan documents the annual QIHEd initiatives and defines goals, objectives, specific actions, responsible parties and time frames targeted for completion or resolution of activities that address quality and safety of clinical care and quality of service. The work plan builds on the recommendations and findings of the previous year's program evaluation. The work plan allows integration of QI reporting and studies from various CHPIV and HNCS departments and includes the requirements for both internal and external reporting. The CHPIV and HNCS staff,

CHPIV QIHEC, and Local Health Commission utilize the work plan as a tool for monitoring the effectiveness of the CHPIV QIHEd Program.
The structure of the work plan outlines the steps necessary to complete the QI cycle: monitoring, planning, implementation, action, assessment and evaluation of outcomes. Each individual department or functional unit retains the responsibility for the implementation and evaluation of their specific activities. It is a dynamic document that CHPIV, with HNCS's assistance, updates regularly to reflect progress on QIHEd activities throughout the year. The QIHEd Work Plan documents the annual QIHEd Program initiatives and delineates:

- Objectives, scope and population demographics.
- Improvement activities planned for the year covering quality and safety of clinical care, quality of service, and members' experience.
- Timeframes within which each activity is to be achieved and/or reported.
- Responsible department(s) and/or person(s) for each activity.
- Goals and benchmarks for each activity.
- Number of objectives met.
- Number of activities met.
- Planned monitoring of previously identified issues.
- Barriers identified when goals are not achieved.
- Follow-up action plan, including continuation status (close, continue, or continue with modifications).

VIII. Confidentiality / Conflict of Interest

CHPIV's Compliance Department is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, appropriate and legitimate use, storage and disclosure of medical information in order to protect the privacy and confidentiality rights of members, employees, providers and the company. CHPIV and HNCS contracts require that providers and practitioners maintain the confidentiality of member information and records. Information or copies or records may be released only to authorized individuals as permitted by state and federal law.

As a public entity, the Plan's QIHEC is subject to the "open meeting" rules of the California Brown Act. Confidential matters presented to the Committee are discussed in a closed session, otherwise all other matters discussed at Committee meetings are open to the public and materials presented in the public portion of meetings are available to the public. Within CHPIV's internal operations, QI activities that will not be presented in the public Committee meetings are conducted and discussed under a code of confidentiality. All documents created as part of the QIHEd Program are maintained in accordance with federal and state law. Materials pertaining to confidential QI review will be marked "confidential" and kept secure. CHPIV, HNCS, its providers, vendors and contracted or delegated entities are responsible for safeguarding all confidential materials.

CHPIV fully complies with the Health Insurance Portability and Accountability Act (HIPAA), which regulates the privacy of protected health information (PHI). CHPIV strictly prohibits any unlawful and unauthorized access to, use or disclosure of member or provider information. Members are informed of these rights through the distribution of the Notice of Privacy Practices.

CHPIV has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees,

providers and the company, and to ensure the appropriate and legitimate use of information. Prior to participation in the QI Program or its non-public committees (Credentialing and Peer Review Subcommittees), participants are educated regarding confidentiality requirements. The CHPIV Chief Compliance Officer is responsible for reviewing, approving and disseminating confidentiality policies and practices regarding the collection, use and disclosure of medical information.

Conflict of Interest

No person(s) will be assigned or selected for a QIHEC where a conflict of interest exists. Physician members will not review or participate in the review of their own care, referrals, or of other practitioners they are in direct competition with or are associated with through financial arrangements. All Peer Review case presentations are blinded as to member and practitioner identification prior to committee review.

IX. QI Program Information Availability

Information about CHPIV's QIHEd Program including program description, activities and progress toward goals is available upon request, to members, prospective members and providers. CHPIV notifies members of the availability of information about the QI Program through the member's evidence of coverage and through the annual member newsletter highlighting the QI Program. Network providers and subcontractors are notified of the availability of information about the QI Program through committee meetings, JOMs, new practitioner/provider welcome letters, Provider Updates (including updates regarding quality improvement findings and outcomes), and through the operations manuals available electronically in the Provider Library on Health Net's online provider portal.

X. Approval

Imperial Local Health Commission Approval

The Imperial Local Health Commission has reviewed and approved this Program Description.

Lee Hindman, MD, Imperial Region
Local Health Commission Chairperson

Date

Gordon Arakawa, MD, Chief Medical Officer
Chair, CHPIV QIHEC

Date

IMPERIAL COUNTY LOCAL HEALTH AUTHORITY
FORMAL RECORD OF ACTION

The following is a formal record of action taken by the governing body of Imperial County Local Health Authority (the "Company").

With respect to the adoption of the CHPIV Governmental 457(b) Plan (the "Plan"), the following resolutions are hereby adopted:

RESOLVED: That the Plan be adopted in the form attached hereto, which Plan is hereby adopted and approved;

RESOLVED FURTHER: That the appropriate officers of the Company be, and they hereby are, authorized and directed to execute the Plan on behalf of the Company;

RESOLVED FURTHER: That American Trust is hereby retained as the Trustee of the Plan; and

RESOLVED FURTHER: That the officers of the Company be, and they hereby are, authorized and directed to take any and all actions and execute and deliver such documents as they may deem necessary, appropriate or convenient to effect the foregoing resolutions including, without limitation, causing to be prepared and filed such reports, documents or other information as may be required under applicable law.

Dated this _____ day of _____, 2025.

Signature: _____

Print Name: Larry Lewis

Title: _____

Dear Plan Sponsor,

Your plan documents are ready for your review and signature. The following actions must be completed to properly adopt and implement the plan:

- **Sign plan documents** – The following documents must be signed and returned to EGPS. Please retain a copy of these signed documents for your records.
  - Adoption Agreement – This contains your selections for the operating provisions of the plan.
  - SECURE/CARES/CAA Amendment – This contains provisions of various pieces of legislation that have taken effect. A subsequent amendment for SECURE and SECURE 2.0 will be available in the future.
  - Consent – This is a document that can be used to memorialize the action taken by the organization to adopt the plan. Alternatively, you may create such a document in your own format and provide it to us.
- **Distribute to eligible employees** – The following documents may be distributed to eligible employees:
  - Plan Description – This is a summary of your plan document that may be provided to the plan participants.
  - Plan Highlights – This is an abbreviated summary of your plan provisions that may be provided to the plan participants.
  - Loan Procedures – This explains the rules for obtaining a loan from the plan.

- **Retain for your records** – The following documents should be reviewed and retained with your other plan records.
  - Basic Plan Document – This document lays out the nonelective provisions of the plan and compliments the Adoption Agreement.

If you have any questions, or you identify any changes that need to be made, please inform EGPS as soon as possible. This plan document supersedes all conversations or communications regarding the operation of the plan.

Sincerely,

EGPS Plan Document Team

ADOPTION AGREEMENT
SECTION 457(b) DEFERRED COMPENSATION PLAN

NOTE: This Plan (Adoption Agreement and Basic Plan Document) has not been approved by the Internal Revenue Service. It must be reviewed by qualified counsel to ensure that it is appropriate for its intended use.

The undersigned adopting employer hereby adopts this Plan. The Plan is intended to qualify as an "eligible deferred compensation plan" within the meaning of Code section 457(b). The Plan shall consist of this Adoption Agreement, its related Basic Plan Document and any related Appendix and Addendum to the Adoption Agreement. Unless otherwise indicated, all Section references are to Sections in the Basic Plan Document.

COMPANY INFORMATION

1. Name of adopting employer (Plan Sponsor): Imperial County Local Health Authority
2. Address: 512 West Aten Rd
3. City: Imperial
4. State: CA
5. Zip: 92251
6. Phone number: 760-332-6447 **7.** Fax number: _____-_____
8. Plan Sponsor EIN: 87-3121369
9. Plan Sponsor fiscal year end: 12/31
10. State of organization of Plan Sponsor: California
11. The term "Employer" includes the Plan Sponsor.

PLAN INFORMATION

A. GENERAL INFORMATION

1. **Plan name:** a. CHPIV Governmental 457(b) Plan
b. _____
2. **Effective Date:**
2a. Original effective date of Plan: 01/01/2025
2b. Is this a restatement of a previously-adopted plan?
☐ Yes ☑ No
2c. If **A.2b** is "Yes", effective date of Plan restatement: _____.
NOTE: If **A.2b** is "No", the Effective Date shall be the date specified in **A.2a**, otherwise the date specified in **A.2c**; provided, however, that when a provision of the Plan states another effective date, such stated specific effective date shall apply as to that provision.
3. **Plan Year** means each 12-consecutive month period ending on 12/31 (e.g. December 31).
NOTE: The Plan Year should correspond to the Participant's taxable year which in most cases is the calendar year.

Plan Type

4. Type of Plan:
i. ☐ Plan maintained by a tax-exempt entity within the meaning of Code section 457(e)(1)(B).
ii. ☑ Governmental Plan maintained by a state or related entity within the meaning of Code section 457(e)(1)(A).

Plan Features

5. Employer/Employee contributions permitted (check all that apply):
a. ☐ Matching Contributions.
b. ☐ Nonelective Contributions.
c. ☑ Participant Deferral Contributions.
d. ☑ If **A.5c** is selected and the Plan is a Governmental Plan, Roth Deferrals are permitted.
e. If Roth Deferrals are permitted, enter the effective date of the Roth Deferrals: 05/09/2025 (no earlier than January 1, 2011).

Compensation

6. Definition of Compensation (check all that apply):
a. ☑ Base salary.
b. ☑ The additional pay specified in **A.7**.

7. If **A.6.b** is selected, enter the additional pay: bonuses, overtime and commissions
8a. Are there any exclusions from the definition of Compensation:
☐ Yes ☑ No
8b. If **A.8a** is "Yes", enter the exclusions from the definition of Compensation: _____
8c. Exclude pay earned before participation in Plan from definition of Compensation:
☐ Yes ☑ No
Unless "No" is checked, Compensation shall include only that compensation which is actually paid to the Participant by the Company during that part of the Plan Year the Participant is eligible to participate in the Plan. Otherwise, Compensation shall include that compensation which is actually paid to the Participant by the Company during the Plan Year.

B. ELIGIBILITY

Eligible Employee

NOTE: If the Plan is not a Governmental Plan, participation in the Plan must be limited to a select group of management or highly compensated employees within the meaning of Title 1 of the ERISA.

1. Subject to the conditions and limitations of **B.2** through **B.4**, the term Eligible Employee shall include Employees who are also (check all that apply):
a. ☐ Officers of the Company in the following positions: _____.
b. ☐ Other management or highly compensated employees in the following classifications/positions: _____.
c. ☐ Employees listed in an appendix to the Adoption Agreement.
d. ☐ All Employees except: _____.
e. ☑ All Employees.
NOTE: Only a Governmental Plan may select **B.1.d** or **B.1.e**.
2. Indicate whether an independent contractor may participate in the Plan:
☐ Yes ☑ No

Eligible Employee - Other

3. In addition to the requirements in **B.1**, the following additional conditions must be met in order for an Employee to become an Eligible Employee (check all that apply):
a. ☐ Must be approved by the Chief Executive Officer of the Plan Sponsor.
b. ☐ Must be approved by the Chief Executive Officer of the Employee's employing entity.
c. ☐ Must be approved by the Board of the Plan Sponsor.
d. ☐ Must be approved by the Board of the Employee's employing entity.
e. ☐ Other requirements listed in **B.4**.
4. If **B.3.e** is selected, enter other requirements: _____

Requirements for Participation

An Eligible Employee shall become eligible to participate in the Plan upon meeting the following conditions in **B.5** through **B.6**:
5. Minimum service requirement for an Eligible Employee to become eligible to be a Participant in the Plan:
i. ☑ None.
ii. ☐ Completion of: _____
iii. ☐ Other: _____
6. Frequency of entry dates:
i. ☐ first day of each calendar month
ii. ☐ first day of each plan quarter
iii. ☐ first day of the first month and seventh month of the Plan Year
iv. ☐ first day of the Plan Year
v. ☑ Other: immediate

Modifications

7a. Indicate whether there are any modifications to the requirements specified in **B.1** - **B.6**:
☐ Yes ☑ No
7b. If **B.7a** is "Yes", specify the modifications: _____.

C. ELECTIONS/CONTRIBUTIONS

1a. If **A.5c** is selected (Participant Deferrals permitted), minimum Participant contribution: None
1b. If **A.5c** is selected (Participant Deferrals permitted), maximum Participant contribution: one hundred percent (100%).
2. If **A.5c** is selected (Participant Deferrals permitted), a Participant may defer accumulated sick pay, accumulated vacation pay, and back pay:
☑ Yes ☐ No

Matching Contributions

3. If **A.5a** is "Yes" (matching contributions are permitted), specify method to allocate matching contributions (Section 5.01(b)):
i. ☐ Pursuant to the formula specified in **C.4**.
ii. ☐ An amount and allocation formula as determined by the Company.
4. If **A.5a** is "Yes" (matching contributions are permitted), and **C.3.i** is selected, indicate the formula to allocate such contributions: _____.
5. If **A.5a** is "Yes" (matching contributions are permitted), indicate any requirements that must be met in the applicable Plan Year to receive an allocation of such contributions: _____.
NOTE: If **C.5** is blank or "None", there are no additional requirements for a Participant to receive an allocation of matching contributions.

Nonelective Contributions

6. If **A.5b** is "Yes" (nonelective contributions are permitted), specify method to allocate nonelective contributions (Section 5.01(b)):
i. ☐ In the ratio that each Participant's Compensation bears to the Compensation of all eligible Participants.
ii. ☐ Pursuant to the formula specified in **C.7.**
iii. ☐ An amount and allocation formula as determined by the Company.
7. If **A.5b** is "Yes" (nonelective contributions are permitted) and **C.6.ii** is selected, indicate the formula to allocate such contributions: _____.
8. If **A.5b** is "Yes" (nonelective contributions are permitted), indicate any requirements that must be met in the applicable Plan Year to receive an allocation of such contributions: _____.
NOTE: If **C.8** is blank or "None", there are no additional requirements for a Participant to receive an allocation of nonelective contributions.

Transfers/Rollovers

9. Transfers/rollover contributions are permitted (Section 5.03 and 5.04):
☑ Yes ☐ No
NOTE: If the Plan is not a Governmental Plan and **C.9** is "Yes", Section 5.03 shall apply. If the Plan is a Governmental Plan and **C.9** is "Yes", Section 5.03 and 5.04 shall apply.

D. EARNINGS/TRUST

Earnings

1. A Participant's Accounts shall be credited with earnings in the following manner:
i. ☐ Fixed rate specified in **D.2**.
ii. ☐ Predetermined investment(s) specified in an appendix to the Adoption Agreement.
iii. ☑ Predetermined investment(s) as specified by the Plan Administrator.
iv. ☐ Mid-term applicable federal rate (as defined pursuant to Code section 1274(d)) for January 1 of the calendar year.
NOTE: If the Plan is a Governmental Plan, **D.1** must be a predetermined investment.
2 **If D.1.i** (fixed rate) is selected, specify the rate: _____.
NOTE: If the rate specified in **D.2** is a published rate, and the entry in **D.2** does not specify when the rate is redetermined, such rate shall be redetermined at the beginning of each Plan Year.
3. If **D.1.ii** or **D.1.iii** (predetermined investments) is selected, specify the extent to which a Participant may choose among the predetermined investments:
i. ☐ A Participant may not choose among predetermined investments.
ii. ☐ As of each Valuation Date.
iii. ☐ As of the first day of each Plan Year.
iv. ☑ Pursuant to Plan Administrator procedures.

4a. If **D.1.ii** or **D.1.iii** (predetermined investments) is selected and **D.3.ii**, **D.3.iii** or **D.3.iv** is selected (Participant direction is allowed), the Plan provides conditions and/or limitations to the Participant's right to select investments:
☐ Yes ☑ No

4b. If **D.1.ii** or **D.1.iii** (predetermined investments) is selected and **D.3.ii, D.3.iii** or **D.3.iv** is selected (Participant direction is allowed) and **D.4a** is "Yes", enter the conditions and/or limitations: _____.

Grantor Trust

5. If the Plan is not a Governmental Plan, specify the extent to which the Company shall establish a grantor trust to pre-fund its obligations for benefits hereunder (Section 7.02(a)):
i. ☐ No grantor trust shall be established.
ii. ☐ The Company may, in its sole discretion, establish a grantor trust.
iii. ☐ The Company shall establish a grantor trust.
NOTE: If the Plan is a Governmental Plan, the Plan shall establish a Trust pursuant to Section 7.02(b).

Valuation Date

6a. Enter Valuation Date:
i. ☐ Last day of Plan Year
ii. ☐ Last day of each Plan quarter
iii. ☐ Last day of each month
iv. ☑ Each business day
v. ☐ Other

6b. If **D.6a.v** is selected, enter the Valuation Date: _____(Must be at least annually).

E. VESTING FOR COMPANY CONTRIBUTIONS

Vesting Service Rules

1. Indicate the method of determining vesting service: _____.
NOTE: Unless otherwise specified in **E.1**, a Participant shall earn one year of vesting service for each calendar year in which he is credited with 1,000 hours of service with the Employer.

Vesting Exceptions

2. Provide for full vesting for a Participant who Terminates employment with the Employer after attainment of Normal Retirement Age while an Employee (Section 5.06):
☐ Yes ☐ No

3. Provide for full vesting for a Participant who Terminates employment with the Employer due to death while an Employee (Section 5.06):
☐ Yes ☐ No

4. Provide for full vesting for a Participant who Terminates employment with the Employer due to disability while an Employee (Section 5.06):
☐ Yes ☐ No

5a. Provide for full vesting for a Participant upon the circumstances described in **E.5b** (Section 5.06):
☐ Yes ☐ No

5b. If **E.5a** is "Yes", describe the other circumstances: _____.

6a. Company contribution vesting schedule:
☐ 100% ☐ 3-7 Year Graded ☐ 2-6 Year Graded ☐ 1-5 Year Graded ☐ 1-4 Year Graded ☐ 5 Year Cliff ☐ 3 Year Cliff ☐ 2 Year Cliff ☐ Other ☐ Pursuant to another plan.
NOTE: If the amount of compensation deferred under the Plan during the taxable year is subject to a vesting schedule, the amount of compensation deferred that is taken into account as a Deferral in the taxable year in which the contribution vests must be adjusted to reflect gain or loss allocable to the compensation deferred until the contribution vests.

6b. If **E.6a** is "Other", enter other vesting schedule: _____

6c. If **E.6a is** "Pursuant to another plan", enter name of other plan: _____

Special Forfeiture Provisions

7a. Provide for special forfeiture provisions (Section 5.06(c)):
☐ Yes ☑ No

7b. If **E.7a** is "Yes", describe any event that shall result in a complete forfeiture of that portion of the Participant's Account specified in **E.7c:** _____**.**
NOTE: If the amount of compensation deferred under the plan during the taxable year is subject to a substantial risk of forfeiture, the amount of compensation deferred that is taken into account as an annual deferral in the taxable year in which the substantial risk of forfeiture lapses must be adjusted to reflect gain or loss allocable to the compensation deferred until the substantial risk of forfeiture lapses.

7c. If **E.7a** is "Yes", a Participant meeting the conditions of **E.7b** shall forfeit the following portion of his or her Account even if such Account is otherwise fully vested: _____.

F. DISTRIBUTIONS

NOTE: All distributions are subject to the minimum distribution requirements of Code section 401(a)(9).

Normal Retirement

1. Normal Retirement Age means Attainment of age: 65.
NOTE: Normal Retirement Age must be on or after the earlier of: (i) age 65, or (ii) the age at which Participants have the right to retire under a basic defined benefit pension plan of the Employer (or money purchase plan if no defined benefit plan). An earlier age may apply for eligible plans of qualified police or firefighters. The age selected may not be later than age 70-1/2.

Time of Payment for Reasons other than Death

2. Benefits may not commence later than the date specified below (Section 6.01):
- **i.** ☐ The earlier of the Required Beginning Date or the number of years specified in **F.3** after the Participant's Termination.
- **ii.** ☐ The earlier of the Required Beginning Date or Normal Retirement Age.
- **iii.** ☑ Required Beginning Date.

NOTE: If **F.2.ii** is selected, payment may not be made earlier than that specified in Section 6.01.

3. If **F.2.i** is selected (number of years after Termination), enter the number years after the Participant's Termination during which benefits must commence (Section 6.01): _____.
NOTE: If zero is entered in **F.3**, distributions shall commence on the 61st day following the distribution event.

Form of Payment for Reasons other than Death

4a. Optional forms of payment payable for reasons other than death of the Participant (check all that apply):
- **i.** ☑ A single lump sum payment.
- **ii.** ☑ Annual installment payments for a period of years (payable on an annual basis) which extends for no longer than the number of years specified in **F.4b**.
- **iii.** ☐ Other optional form of benefit specified in **F.4c.**

4b. If **F.4a.ii** (annual installments) is selected, enter the maximum number of years over which payments may be made: 15.
NOTE: May not extend beyond the life expectancy of the Participant and Beneficiary.

4c. If **F.4a.iii** (Other) is selected, describe other optional form of benefit: _____.

Payment on Participant Death

5. Distributions on account of the death of the Participant shall be made in accordance with one of the following payment forms (Section 6.05):
- **i.** ☐ Pay entire remaining Account by end of the first calendar year following the date of death.
- **ii.** ☑ Participant's Beneficiary shall be entitled to make any elections as to timing and form of distribution as were available to the Participant at the time of death subject to the minimum distribution requirements of Code section 401(a)(9).

Unforeseeable Emergency

6a. A Participant may receive a distribution upon the occurrence of an unforeseeable emergency (Section 6.04):
☑ Yes ☐ No

6b. If **F.6a** is "Yes", **A.5c** (Participant Deferral Contributions) is selected, the Plan is a Governmental Plan, and Roth Deferrals are permitted, permit unforeseeable emergency distributions from Roth Deferral Accounts:
- **i.** ☑ Yes
- **ii.** ☐ Yes - But only if the withdrawal from the Roth Deferral Account qualifies as a "qualified distribution" within the meaning of Code section 402A(d)(2).

iii. ☐ No

Small Distributions

7. A Participant may make a one-time election to receive a distribution of a small balance ($5,000 or less) as permitted by Code section 457(e)(9)(A) (Section 6.03):
☑ Yes ☐ No

Medium of Payment

8. Medium of distribution from the Plan:
i. ☑ Cash only
ii. ☐ Cash or in-kind
iii. ☐ In-kind only

Transfers

9a. Specify whether transfers may be made to another plan (Section 6.08):
☑ Yes ☐ No
NOTE: A transfer shall only be permitted to the extent that it is permissible in accordance with Code section 457(e)(10) and Treas. Reg. section 1.457-10(b).
NOTE: Governmental Plans are also subject to the direct rollover rules in Section 6.09.
9b. If the Plan is a Governmental Plan, specify whether service credit transfers may be made to another defined benefit governmental plan (Section 6.10):
☑ Yes ☐ No

Death or Disability during Qualified Military Service

10a. For benefit accrual purposes, a Participant that dies or becomes disabled while performing qualified military service will be treated as if he had been employed by the Company on the day preceding death or disability and terminated employment on the day of death or disability pursuant to Code section 414(u)(9), Notice 2010-5 and any superseding guidance (Section 6.12):
☐ Yes ☑ No
10b. If **F.10a** is "Yes", enter the effective date: _____(must be on or after January 1, 2007).

Loans/Inservice

11. If the Plan is a Governmental Plan, specify whether Participant loans may be made (Section 6.13):
☑ Yes ☐ No
12. If the Plan is a Governmental Plan and **C.9** permits rollover contributions, specify whether a Participant may receive an inservice withdrawal of his rollover Account (Section 6.07):
☑ Yes ☐ No
13. Specify whether a Participant may receive an inservice withdrawal of his Account upon attainment of age 70-1/2:
☑ Yes ☐ No

2009 Required Minimum Distributions

14a. If the Plan is a Governmental Plan, indicate the extent to which participants and beneficiaries have an election to receive distributions that include 2009 RMDs:
i. ☑ Default to continue 2009 RMDs.
ii. ☐ Default to discontinue 2009 RMDs.
iii. ☐ Other: _____.
NOTE: If "Other" is selected, the below provisions will not apply except to the extent specified.
14b. Direct Rollovers of 2009 RMDs. For purposes of the direct rollover provisions of the Plan, the following will also be treated as eligible rollover distributions in 2009:
i. ☑ None. 2009 RMDs will not be treated as eligible rollover distributions in 2009.
ii. ☐ 2009 RMDs only.
iii. ☐ Extended 2009 RMDs only.
iv. ☐ 2009 RMDs and Extended 2009 RMDs.

G. PLAN OPERATIONS

Plan Administration

1a. Designation of Plan Administrator (Section 7.01):
- **i.** ☑ Plan Sponsor
- **ii.** ☐ Committee appointed by Plan Sponsor
- **iii.** ☐ Other

1b. If **G.1a.iii** is selected, Name of Plan Administrator: _____

2a. Type of indemnification for the Plan Administrator (and if applicable, the Trustee):
- **i.** ☑ Standard according to Section 7.03.
- **ii.** ☐ Custom.

2b. If **G.2a.ii** (Custom) is selected, indemnification for the Plan Administrator (and if applicable, the Trustee) is provided pursuant to an Addendum to the Adoption Agreement.

H. MISCELLANEOUS

Failure to properly fill out the Adoption Agreement may result in the failure of the Plan to achieve its intended tax consequences and may further result in significant tax penalties.

The Plan shall consist of this Adoption Agreement, its related Basic Plan Document #457B and any related Appendix and Addendum to the Adoption Agreement.

The undersigned agree to be bound by the terms of this Adoption Agreement and Basic Plan Document and acknowledge receipt of same. The Plan Sponsor caused this Plan to be executed this _____ day of _____, 2025.

5/14/2025

IMPERIAL COUNTY LOCAL HEALTH AUTHORITY:

DocuSigned by:

Signature: Lawrence E Lewis
BA8759FA977D477...

Print Name: Lawrence E Lewis

Title/Position: CEO

IMPERIAL COUNTY LOCAL HEALTH AUTHORITY
FORMAL RECORD OF ACTION

The following is a formal record of action taken by the governing body of Imperial County Local Health Authority (the "Company").

With respect to the adoption of the CHPIV Governmental 457(b) Plan (the "Plan"), the following resolutions are hereby adopted:

RESOLVED: That the Plan be adopted in the form attached hereto, which Plan is hereby adopted and approved;

RESOLVED FURTHER: That the appropriate officers of the Company be, and they hereby are, authorized and directed to execute the Plan on behalf of the Company;

RESOLVED FURTHER: That American Trust is hereby retained as the Trustee of the Plan; and

RESOLVED FURTHER: That the officers of the Company be, and they hereby are, authorized and directed to take any and all actions and execute and deliver such documents as they may deem necessary, appropriate or convenient to effect the foregoing resolutions including, without limitation, causing to be prepared and filed such reports, documents or other information as may be required under applicable law.

Dated this _____ day of _____, 2025.

5/14/2025

Signature: DocuSigned by: Lawrence E Lewis BA8759FA977D477...

Print Name: Lawrence E Lewis

Title: CEO

CHPIV GOVERNMENTAL 457(B) PLAN
PLAN HIGHLIGHTS

Eligibility: All employees are eligible to participate in the Plan.

You may enter the Plan at any time specified in the "Enrollment Periods" section below.

Enrollment Periods: On the immediate after you meet the eligibility criteria specified above.

Contributions: You may elect to defer up to one hundred percent (100%) of your Compensation on a pre-tax basis. You may also elect to make special 'Roth' contributions to the Plan on an after-tax basis. You may elect to defer accumulated sick pay, accumulated vacation pay, and back pay.

Contribution Limit: Federal tax law places a limit on the amount that you may contribute to the Plan each year. The limit is the lesser of: $23,500 (in 2025) or 100% of your total compensation for the calendar year.

A Participant who will attain age 50 or more by the end of the calendar year is permitted to elect an additional amount of contributions, up to the maximum age 50 catch-up amount for the year. The maximum dollar amount of the age 50 catch-up contributions for a year is $7,500 (in 2025). The age 50 catch-up does not apply for any year for which a higher limitation applies under the make-up contribution described above.

Rollovers: The Plan may accept a rollover contribution made on behalf of any employee who is eligible to participate in the plan.

Vesting: You will be 100% vested in the amounts you contribute to the plan, including any rollover contributions.

Investing Plan Contributions: Your Account will be credited with earnings that will reflect a "market basket" of predetermined investments. You may select which investments will make up your market basket. You may change the your investment selections at such times as specified by the Plan Administrator.

CHPIV GOVERNMENTAL 457(B) PLAN
PLAN HIGHLIGHTS

Distributions: Upon your termination of employment with the Company, you are entitled to receive a distribution of your Account in any form of distribution permitted by the Plan.

Benefits may not commence later than your required beginning date. Your required beginning date is April 1st of the calendar year following the calendar year in which you attain age 70-1/2 or terminate, whichever is later.

You may receive your Account in the following forms:

Single lump sum payment

Annual installment payments for a period of years (payable on an annual basis) which extends for no longer than 15 years

Distributions from the Plan may be made in cash.

You may receive a distribution upon the occurrence of an unforeseeable emergency.

You may be able to receive up to $5,000 of your Account in a one-time lump sum before your termination (either with or without your consent) under certain conditions. Contact the Plan Administrator for more information.

You may receive an inservice withdrawal of your rollover Account at any time.

You may receive an inservice withdrawal from your Account if you have not separated from employment after you attain: 59-1/2.

Loans: You may make a loan from the Plan. Contact the Plan Administrator for details on how loans are administered.

Contact Information: Plan Administrator:

Imperial County Local Health Authority
512 West Aten Rd
Imperial, CA 92251
760-332-6447

CHPIV GOVERNMENTAL 457(B) PLAN
PLAN HIGHLIGHTS

Note: These plan highlights are intended to be a very concise overview of plan features. For a detailed description of plan features, please review the Plan Description or contact the Plan Administrator for more information. The plan features described in these plan highlights are subject to change and in the event of a discrepancy between the legal plan document and these highlights (or any other summary of plan features), the plan document shall control.

CHPIV GOVERNMENTAL 457(B) PLAN

PLAN DESCRIPTION

May 2025

CHPIV GOVERNMENTAL 457(B) PLAN

PLAN DESCRIPTION

TABLE OF CONTENTS

INTRODUCTION

Imperial County Local Health Authority (the "Company") established the CHPIV Governmental 457(b) Plan (the "Plan") effective 01/01/2025.

Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

ELIGIBILITY FOR PARTICIPATION

Eligible Employee

All employees are "Eligible Employees".

Date of Participation

You will become a Participant eligible to participate in the Plan on the day you first perform an hour of service as an Eligible Employee.

ELECTIONS/CONTRIBUTIONS

Participant Contributions

When you become eligible to participate in the Plan, you may begin contributing to the Plan. All contributions will be credited to an account established in your behalf. Your contributions to the Plan are not subject to federal income tax but may be subject to social security and medicare taxes.

Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

You may elect to reduce your Compensation (defined below) and make a contribution to the Plan. You may elect to defer up to one hundred percent (100%) of your Compensation. You may also make a contribution of accumulated sick pay, accumulated vacation pay, and back pay to the Plan.

Roth Contributions

Effective 05/09/2025, the Plan allows a newer type of participant contribution to the Plan. This new type of contribution is known as a Roth Contribution and is very much like a contribution to a Roth IRA. Like a Roth IRA, the Roth Contribution to the Plan is made by you on an after-tax basis, but if certain requirements are met, a "qualified distribution" from your Roth Contribution Account in the Plan will not be taxed. However, unlike a Roth IRA, there are no income limitations on who may make a Roth Contribution.

Roth Contributions are participant contributions that are made in the same manner as your pre tax participant contributions. You must designate how much you would like to contribute on a pre-tax basis (normal contribution) and how much you would like to contribute as an after-tax Roth Contribution. You are not required to make any Roth Contributions. You may continue to designate all of your participant contributions as normal pre-tax contributions.

The sum of your Roth Contributions and regular pre-tax participant contributions may not exceed the contribution limit mentioned below.

As was mentioned above, a "qualified distribution" of your Roth Contributions (and earnings) is not taxable. A "qualified distribution" must be made more than five years after the first Roth Contribution is made and must meet at least one of the following requirements:

(i) the distribution must be made after you attain age 59-1/2;

(ii) the distribution must be made to your beneficiary after your death; or

(iii) the distribution must be made on account of your disability.

Please note that Roth Contributions are not suitable for everyone. Please consult with your tax advisor before making any Roth Contributions to the Plan.

Contribution Limit

Federal tax law places a limit on the amount that you may contribute to the Plan each year. The limit is the lesser of:

(1) $23,500 (in 2025); or

(2) 100% of your total compensation for the calendar year.

Make Up Contributions

During the last 3 calendar years ending before the year in which you attain age 65, you may be able to use a higher contribution limit. The "make up" limit is the lesser of:

(1) 2 times the $23,500 limit (in 2025); or

(2) The sum of the unused portion of the $23,500 (in 2025) in any prior year of participation in the Plan.

Age 50 Catch-Up Contributions

A Participant who will attain age 50 or more by the end of the calendar year is permitted to elect an additional amount of contributions, up to the maximum age 50 catch-up amount for the year. The maximum dollar amount of the age 50 catch-up contributions for a year is $7,500

(in 2025). The age 50 catch-up does not apply for any year for which a higher limitation applies under the make-up contribution described above.

Transfers/Rollover Contributions

If you are a participant, you may request to have all or a portion of an eligible rollover distribution paid to the Plan.

In addition, the Plan Administrator may accept a transfer of assets to the Plan from another section 457(b) plan. Such a transfer is permitted only if the other plan provides for such direct transfer and if such transfer is permitted by applicable federal tax regulations. The Plan Administrator may require that the transfer be in cash or other property acceptable to the Plan Administrator.

Compensation

Compensation means base salary and bonuses, overtime and commissions. Compensation will include amounts which are paid to you during the Plan Year.

CREDITING EARNINGS ON PARTICIPANT ACCOUNTS

Determination of Amount

Your Account will be credited with earnings that will reflect a "market basket" of predetermined investments. You may select which investments will make up your market basket. You may change your investment selections at such times as specified by the Plan Administrator.

When Earnings Are Credited

Your account will be adjusted daily for earnings/losses.

Expenses

The Company may charge your Account with any or all of the expenses involved in the establishment or ongoing operation of the Plan.

Trust

The Company will establish a trust fund to hold all contributions to the Plan. As an alternative, the Company may invest Plan assets in custodial accounts and/or annuity contracts as permitted by federal law.

VESTING

Participant Contributions

You will have a fully vested and nonforfeitable interest in your contributions to the Plan (including rollover contributions and transfers from another plan).

DISTRIBUTIONS

Time of Distribution

Upon your termination of employment with the Company, you are entitled to receive a distribution of your Account in any form of distribution permitted by the Plan.

Benefits may not commence later than your required beginning date. Your required beginning date is April 1st of the calendar year following the calendar year in which you attain age 70-1/2 (for Participants born before July 1, 1949) or age 72 (for Participants born after June 30, 1949) or terminate, whichever is later.

Form of Payment

You may receive your Account in the following forms of payment:

Single lump sum payment.

Annual installment payments for a period of years (payable on an annual basis) which extends for no longer than 15 years.

Payment on Participant Death

In the event of your death, your beneficiary will be entitled to make any elections as to timing and form of distribution as were available to you at the time of your death subject to the minimum distribution requirements of federal tax law.

You have the right to designate one or more primary and one or more secondary Beneficiaries to receive any benefit becoming payable at your death. You are entitled to change your Beneficiaries at any time and from time to time by filing written notice of such change with the Plan Administrator. If you fail to designate a Beneficiary, or in the event that all designated primary and secondary Beneficiaries die before you, the death benefit will be payable to your spouse or, if there is no spouse, to your estate.

Unforeseeable Emergency

You may receive a distribution upon the occurrence of an unforeseeable emergency. An unforeseeable emergency is a severe financial hardship that may not otherwise be relieved by reimbursement or compensation from insurance, by liquidation of your assets (to the extent the

liquidation of such assets would not itself cause severe financial hardship), or by cessation of deferrals under the Plan.

Your Roth Deferrals may be withdrawn upon the occurrence of an unforeseeable emergency in the same manner as other deferrals. Please note however, that the income on the Roth deferrals may be taxable (and subject to penalties for early withdrawal) if the withdrawal is not a "qualified distribution."

Small Distributions

The Plan Administrator may establish uniform guidelines under which up to $5,000 of your Account may be distributed in a lump sum before your termination (either with or without your consent). In order to qualify for the distribution, no deferrals may have been credited to your Account in the preceding twenty-four (24) months, and no prior small distribution may have been made to you under this special rule.

Medium of Payment

You may receive a distribution from the Plan in the form of cash.

Transfers/Rollovers

The Company may transfer your account to another section 457(b) plan provided that such transfer complies with applicable federal regulations. In addition, you may roll over a distribution from the Plan to another eligible retirement plan. If the vested amount of your Account exceeds $1,000 and you do not timely return your election forms, the Plan Administrator must transfer your Account to an IRA established in your name; unless the distribution occurs after the later of your Normal Retirement Age or age 62. The mandatory distribution will be invested in an IRA designed to preserve principal and provide a reasonable rate of return and liquidity. For further information concerning the Plan's rollover provisions, the IRA provider and the fees and expenses attendant to the IRA please contact the plan administrator at the phone number found in the "ADMINISTRATIVE INFORMATION" section at the end of this plan description.

You may rollover a distribution that otherwise qualifies for direct rollover treatment, directly into a Roth IRA, even if it does not include a Roth account. You will want to seek professional tax advice, as this type of rollover distribution will be taxable to you. (It is designed to avoid the two step conversion process previously required to convert a non-Roth IRA into a Roth IRA after paying tax on the conversion.)

You may also transfer service credit to another defined benefit governmental plan. If you are interested in this feature, please contact the Plan Administrator for more information.

Loans

You may receive a loan from the Plan. If you are interested in this loan feature, please contact the Plan Administrator for more information.

Inservice Withdrawals

Subject to any Plan Administrator procedures, you may receive an inservice withdrawal of your rollover Account.

You may receive an inservice withdrawal from your Account if you have not separated from employment after you attain: 59-1/2.

MISCELLANEOUS

Domestic Relations Orders

Your benefits under the Plan may be assigned to other people in accordance with a qualified domestic relations order. You may obtain, without charge, a copy of the Plan's procedures regarding qualified domestic relations orders from the Plan Administrator.

Amendment and Termination

The Company may amend, terminate or merge the Plan at any time.

Fees

Your account may be charged for some or all of the costs and expenses of operating the Plan. Such expenses include, but are not limited to, investment expenses and costs to process plan distributions and domestic relations orders.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Plan Year

The plan year ends on 12/31.

ADMINISTRATIVE INFORMATION

The Plan Sponsor and Plan Administrator is Imperial County Local Health Authority.

Its address is 512 West Aten Rd Imperial, CA 92251.

Its telephone number is 760-332-6447.

Its Employer Identification Number is 87-3121369.

IMPERIAL COUNTY LOCAL HEALTH AUTHORITY
FORMAL RECORD OF ACTION

The following is a formal record of action taken by the governing body of Imperial County Local Health Authority (the "Employer").

With respect to the amendment of the CHPIV Governmental 457(b) Plan (the "Plan"), the following resolutions are hereby adopted:

RESOLVED: That the Plan be amended in the form attached hereto, which amendment is hereby adopted and approved;

RESOLVED FURTHER: That the appropriate officers of the Employer be, and they hereby are, authorized and directed to execute said amendment on behalf of the Employer;

RESOLVED FURTHER: That the officers of the Employer be, and they hereby are, authorized and directed to take any and all actions and execute and deliver such documents as they may deem necessary, appropriate or convenient to effect the foregoing resolutions including, without limitation, causing to be prepared and filed such reports, documents or other information as may be required under applicable law.

Dated this _____ day of _____, 2025.

Signature: _____

Print Name: _____

Title: _____

CHPIV GOVERNMENTAL 457(B) PLAN

SECURE/CARES/CAA AMENDMENT

This Amendment is intended as a good faith effort to comply with the requirements of the Further Consolidated Appropriations Act, 2020, including the SECURE Act provisions, the Coronavirus, Aid, Relief and Economic Security (CARES) Act, and the Consolidated Appropriations Act, 2021 (CAA), and corresponding guidance (the "Applicable Law"). This Amendment is to be construed in accordance with the Applicable Law and both the Amendment and the Applicable Law will supersede any inconsistent Plan provisions.

OPTIONAL PROVISIONS:

For each item below, if the check boxes are empty, the *italicized* provision will apply.

1. Treatment of 2020 RMDs (see Section A. below)
   *Effective 01/01/2020, unless the Participant or beneficiary chooses otherwise, a Participant or beneficiary who would have been required to receive a 2020 RMD will **not** receive this distribution.*

   Effective _____ (no earlier than 01/01/2020):

   - ☐ Unless the Participant or beneficiary chooses otherwise, a Participant or beneficiary who would have been required to receive a 2020 RMD will **not** receive this distribution.

   - ☐ Unless the Participant or beneficiary chooses otherwise, a Participant or beneficiary who would have been required to receive a 2020 RMD will receive this distribution.

2. 2020 RMDs as Direct Rollovers (see Section A. below)
   A direct rollover is not offered for 2020 RMDs or Extended 2020 RMDs.

   For purposes of the direct rollover provisions of the Plan, the following will be treated as eligible rollover distributions in 2020:

   - ☐ 2020 RMDs.

   - ☐ 2020 RMDs and Extended 2020 RMDs.

   - ☐ 2020 RMDs, but only if paid with an additional amount that is an eligible rollover distribution without regard to Code section 401(a)(9)(l).

3. Qualified Birth or Adoption Distributions (see Section C. below)
The Plan does not permit qualified birth or adoption distributions as a separate distribution event.

    ☐ Effective _____ (no earlier than 01/01/2020), the Plan permits qualified birth or adoption distributions as a separate distribution event.

    ☐ The following limitations and conditions apply: _____.

4. Portability of Lifetime Income Options (see Section D. below)
The Plan does not permit "qualified distributions" or "qualified plan distribution annuity contracts" of lifetime income investment options.

    ☐ The Plan permits "qualified distributions" or "qualified plan distribution annuity contracts" of lifetime income investment options when such investment options are no longer authorized to be held as an investment option under the Plan effective: _____ (no earlier than the plan year beginning after 12/31/2019).

    ☐ The following limitations and conditions apply: _____.

5. Time of Payment for Reasons other than Death
The existing Plan provisions, if any, remain in effect for distributions to a Participant who has not separated from employment (e.g., benefits may not commence until Required Beginning Date).

    ☑ Effective 01/01/2025 (no earlier than 01/01/2020), the Plan permits distributions to a Participant who has not separated from employment if the Participant attains: 59-1/2 (age cannot be less than 59-1/2).

STANDARD PROVISIONS:

A. Required Minimum Distributions

In defining Required Beginning Date or determining required minimum distributions, any references to age 70-1/2 are replaced with: age 70-1/2 (for Participants born before 07/01/1949) or age 72 (for Participants born after 06/30/1949).

Notwithstanding other provisions of the Plan to the contrary and if selected above, a Participant or beneficiary who would have been required to receive required minimum distributions in 2020 (or paid in 2021 for the 2020 calendar year for a Participant with a required beginning date of 04/01/2021) but for the enactment of section 401(a)(9)(l) of the Code ("2020 RMDs"), and who would have satisfied that requirement by receiving distributions that are either: (1) equal to the 2020 RMDs, or (2) one or more payments (that include the 2020 RMDs) in a series of substantially equal periodic payments made at least annually and expected to last for the life (or life expectancy) of the Participant, the joint lives (or joint life expectancies) of the Participant and the Participant's designated beneficiary, or for a period of at least 10 years ("Extended 2020

RMDs"), may receive those distributions.

B. Distribution on Account of Death for Certain Eligible Retirement Plans

Whether before or after distribution has begun, a Participant's entire interest will be distributed to the designated beneficiary by 12/31 of the calendar year containing the tenth anniversary of the Participant's death unless the designated beneficiary meets the requirements of an "eligible designated beneficiary". An "eligible designated beneficiary" may receive distributions over the life of such designated beneficiary. If there is no designated beneficiary as of 09/30 of the year following the year of the Participant's death, the Participant's entire interest will be distributed by 12/31 of the calendar year containing the fifth anniversary of the Participant's death.

An "eligible designated beneficiary" is defined as any designated beneficiary who is: (i) the surviving spouse of the Participant; (ii) a minor child of the Participant; (iii) disabled; (iv) a chronically ill individual; or (v) an individual who is not more than 10 years younger than the Participant. The determination of whether a designated beneficiary is an "eligible designated beneficiary" is made as of the date of death of the Participant. If an "eligible designated beneficiary" dies before the portion of the Participant's interest is entirely distributed, the remainder of such portion must be distributed within 10 years after the death of such "eligible designated beneficiary".

C. Qualified Birth or Adoption Distributions

To the extent provided above, a Participant may receive a distribution up to $5,000 during the 1-year period beginning on the date on which the Participant's child is born or on which the legal adoption by the Participant of an eligible adoptee is finalized. An eligible adoptee is any individual (other than a child of the Participant's spouse) who has not attained age 18 or is physically or mentally incapable of self-support. The $5,000 maximum is an aggregate amount of such distributions from all plans maintained by the Employer.

D. Portability of Lifetime Income Investments

To the extent provided above, any amounts invested in a "lifetime income investment" may be distributed through either "qualified distributions" or "qualified plan distribution annuity contracts" no earlier than 90 days prior to the date that such "lifetime income investment" may no longer be held as an investment option under the Plan.

The following terms are used in this section:

"Qualified distribution" means a direct trustee-to-trustee transfer described in Code section 401(31)(A) to an eligible retirement plan (as defined in Code section 402(c)(8)(B)).

"Qualified plan distribution annuity contract" means an annuity contract purchased for a Participant and distributed to the Participant by a plan or contract described in subparagraph (B) of Code section 402(c)(8) (without regard to clauses (i) and (ii) thereof).

"Lifetime income investment" means an investment option which is designed to provide an employee with election rights which: (a) are not uniformly available with respect to other investment options under the plan, and (b) are to a "lifetime income feature" available through a contract or other arrangement offered under the plan (or under another eligible retirement plan (as so defined), if paid by means of a direct trustee-to-trustee transfer described in Code section 401(31)(A) to such other eligible retirement plan).

"Lifetime income feature" means: (a) a feature which guarantees a minimum level of income annually (or more frequently) for at least the remainder of the life of the employee or the joint lives of the employee and the employee's designated beneficiary, or (b) an annuity payable on behalf of the employee under which payments are made in substantially equal periodic payments (not less frequently than annually) over the life of the employee or the joint lives of the employee and the employee's designated beneficiary.

E. Disaster or Coronavirus-Related Relief

Notwithstanding any provision of the Plan to the contrary, the Plan may grant temporary disaster or coronavirus-related relief in compliance with Code sections 1400M and 1400Q, section 15345 of the Food, Conservation, and Energy Act of 2008, section 702 of the Heartland Disaster Tax Relief Act of 2008, section 502 of the Disaster Tax Relief and Airport and Airway Extension Act of 2017, section 11028 of the Tax Cuts and Jobs Act of 2017, section 20102 of the Bipartisan Budget Act of 2018, subtitle II of Division Q of the Further Consolidated Appropriations Act, 2020, section 2202 of the Coronavirus, Aid, Relief and Economic Security Act, and Title III of Division EE of the Consolidated Appropriations Act, 2021 ("Applicable Law"). This Section only applies to the extent the Plan has provided some or all of the relief listed below in compliance with Applicable Law.

A. Qualified Distributions

I. "Qualified Distribution" means a distribution to a qualified individual within the applicable time periods as defined in the relevant sections of Applicable Law which may not exceed $100,000 in aggregate from all plans maintained by the Employer.

II. If the Plan permits rollover contributions, at any time during the 3-year period beginning on the day after the Qualified Distribution was received, an individual may contribute as a rollover to the Plan an aggregate amount that does not exceed the amount of the Qualified Distribution.

III. If the Plan permits rollover contributions, an individual who received a withdrawal for the purchase of a home, but could not use the withdrawal amount due to the disaster, may contribute as a rollover to the Plan an aggregate amount that does not exceed the amount of the withdrawal amount within the applicable time periods as defined in the relevant sections of Applicable Law.

B. Expanded Loan Provisions

I. The maximum loan limit under Code section 72(p)(2)(A) may be applied by substituting "$100,000" for "$50,000" and substituting "the present value" for "one-half the present value" under the Loan Procedures for a qualified individual within the applicable time periods as defined in the relevant sections of Applicable Law.

II. The loan repayment may be delayed for 1 year for a qualified individual within the applicable time periods as defined in the relevant sections of Applicable Law.

III. Subsequent repayments will be adjusted to reflect the 1-year delay and any interest accrued during such delay.

IV. The 1-year delay will be disregarded in determining the 5-year maximum term of loans under Code section 72(p)(2)(B) and (C).

IN WITNESS WHEREOF, the Employer has caused this Amendment to be executed this _____ day of _____, 2025.

IMPERIAL COUNTY LOCAL HEALTH AUTHORITY:

Signature:

_____

Print Name:

_____

Title/Position:

_____

CHPIV GOVERNMENTAL 457(B) PLAN
SUMMARY OF MATERIAL MODIFICATIONS

The purpose of this Summary of Material Modifications is to inform you of changes that have been made to the CHPIV Governmental 457(b) Plan. These changes affect the information previously provided to you in the Plan Description. The Plan Description is modified as described below.

DISTRIBUTIONS

Under the "Time of Distribution" section, any reference to "age 70-1/2" is replaced with "age 70-1/2 (for Participants born before 07/01/1949) or age 72 (for Participants born after 06/30/1949)".

Inservice Withdrawals

Effective 01/01/2025, you may receive an inservice withdrawal from your Account if you have not separated from employment after you attain: 59-1/2.

CHPIV GOVERNMENTAL 457(B) PLAN

LOAN PROCEDURES

This document contains important information about the procedures for obtaining a loan from the Plan. The following rules shall apply to the loan program:

Procedure for Applying for a Loan. If you are an active Participant in the CHPIV Governmental 457(b) Plan, you may apply for a loan from the Plan. You must complete a loan application form and submit the completed form and supporting materials to the Plan Administrator. All loan applications will be reviewed on a uniform and nondiscriminatory basis and your loan will be approved if the Plan Administrator determines that you have the ability to repay the loan and that the loan is adequately secured. Loan application forms may be obtained from the Plan Administrator.

Administration of the Plan Loan Program. The Plan loan program is administered by the Plan Administrator.

Promissory Note. If your loan is approved, you will be required to sign a promissory note.

Type and Amount of Loan. The Plan does not restrict the purposes for which loans may be made. However, the Plan does set maximum and minimum limits on the amount of a loan.

Maximum Amount of Loan. A loan cannot be greater than 50% of the vested accrued benefit under the Plan. Additionally, the loan cannot exceed $50,000, reduced by the excess (if any), of the highest outstanding balance of loans from the Plan during the 12-month period ending on the day before the date a new loan is made, over the outstanding balance of loans from the Plan on the date the new loan is made.

Roth Contribution Account. The Plan Administrator will determine whether you may receive a loan from your Roth Deferral Account. If the Plan Administrator allows loans from your Roth Deferral Account, the Plan Administrator will specify an ordering rule for loans. The ordering rule will determine whether loans will be made first or last from your Roth Deferral Account or in any combination of your Roth Deferral Account and any other Account.

Repayment. Loans must be paid in equal payments over a period not extending beyond five years from the date of the loan; unless you certify in writing to the Plan Administrator that the loan is to be used to acquire any dwelling unit which within a reasonable time is to be used (determined at the time the loan is made) as your principal residence. If you go on a leave of absence or go on active service in the military, you may be able to suspend loan repayments. Please contact the Plan Administrator to determine whether your leave of absence qualifies. You must repay a loan in accordance with the repayment schedule or you may repay the loan in full. Partial early loan payoffs are not permitted. The loan will become payable in full on your termination of employment.

Maximum Number of Loans. The maximum number of loans outstanding at any one time is one.

Minimum Loan Amount. The minimum loan amount is $1,000.

Interest Rate. This Plan uses the prime interest rate listed in The Wall Street Journal plus 1%. However, you may qualify for a lower interest rate if you are on active duty in the military. If you are on active duty, please contact the Plan Administrator to determine whether you qualify for the lower interest rate.

Collateral. Your vested accrued benefit under the Plan will serve as collateral for the loan. However, a maximum of 50% of your vested accrued benefit may be used as collateral.

Payroll Deduction. Payments will be made through payroll deduction from each regular paycheck.

Fees. The Plan charges a loan processing fee of $The Plan may charge a loan processing fee that will be deducted from the proceeds of the loan. This amount will be deducted from the proceeds of the loan.

Default. Your loan will be in default if a scheduled payment becomes 90 days overdue. Upon default, the entire balance of the loan will be immediately due and entire balance be a treated as a taxable distribution to you. In addition, your vested accrued benefit may be reduced by the amount of the outstanding principal and interest on the loan. In other cases, this offset will not occur until you are entitled to receive benefits (for example, upon your termination of employment).

EGPS, Inc.

BASIC PLAN DOCUMENT #457B

EGPS, INC.

TABLE OF CONTENTS

ARTICLE 1 INTRODUCTION

Section 1.01 PLAN

This document ("Basic Plan Document") and its related Adoption Agreement are intended to provide deferred compensation for Eligible Employees of the Company. This Plan is intended to constitute an "eligible deferred compensation plan" within the meaning of Code section 457(b) and, if the Plan is not a Governmental Plan, a top hat plan within the meaning of ERISA sections 201(2), 301(a)(3) and 401(a)(1). The provisions of this Plan are intended to comply with requirements of Code section 457 in form and operation and shall be interpreted in a manner consistent with such Code section and regulations or guidance promulgated pursuant thereto.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Employees of the Company on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the Company whose employment terminated prior to the Effective Date, shall be determined under the provisions of the Plan, as in effect from time to time prior to that date.

ARTICLE 2 DEFINITIONS

"Account" means the book entry account maintained with respect to each Participant pursuant to Article 5.

"Adoption Agreement" means the document executed in conjunction with this Basic Plan Document that contains the optional features selected by the Plan Sponsor.

"Beneficiary" means the person or persons designated by the Participant to receive distributions from the Participant's Account after the Participant's death. Upon enrollment, the Participant shall designate a Beneficiary to receive distributions from the Participant's Account in the event of the Participant's death. A Participant may change his or her designated Beneficiary at any time. A Participant may designate any person or persons as Beneficiaries. Unless otherwise provided in the Beneficiary designation form, each designated Beneficiary shall be entitled to equal shares of the benefits payable after the Participant's death. If the Participant fails to designate a Beneficiary, or if no designated Beneficiary survives the Participant for a period of fifteen (15) days, then the Participant's surviving spouse shall be the Beneficiary. If the Participant has no surviving spouse, or if the surviving spouse does not survive the Participant for a period of fifteen (15) days, then the estate of the Participant shall be the Beneficiary.

"Code" means the Internal Revenue Code of 1986, as amended from time to time.

"Company" means the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

"Compensation" shall have the meaning set forth in the Adoption Agreement. Compensation for an independent contractor shall include payment by the Company to the independent contractor. Effective for Plan Years beginning after December 31, 2008, Compensation shall include differential wage payments (as defined in Code section 3401(h)(2)) pursuant to Code section 414(u)(12), Notice 2010-5 and any superseding guidance.

"Deferral" means, the amount of Compensation deferred, whether by salary reduction or by employer contribution. The amount of Compensation deferred under the Plan is taken into account as an annual deferral in the taxable year of the Participant in which deferred, or, if later, the year in which the amount of Compensation deferred is no longer subject to a substantial risk of forfeiture. The term "Deferral" shall not include transfers and rollovers from another plan described in Article 5. To the extent provided in the Adoption Agreement, a Participant may also defer accumulated sick pay, accumulated vacation pay, and back pay.

If the amount of Compensation deferred under the Plan during a taxable year is not subject to a substantial risk of forfeiture, the amount taken into account as an annual deferral is not adjusted to reflect gain or loss allocable to the compensation deferred. If, however, the amount of Compensation deferred under the Plan during the taxable year is subject to a substantial risk of forfeiture, the amount of Compensation deferred that is taken into account as an annual deferral in the taxable year in which the substantial risk of forfeiture lapses must be adjusted to reflect gain or loss allocable to the Compensation deferred until the substantial risk of forfeiture lapses.

"Deferral Agreement" means the agreement between an Employer and a Participant, including any amendments thereto, which specifies the amount of Deferrals to be made by the Employee. Each Deferral Agreement or amendment thereto shall be made or confirmed in writing under procedures established by the Plan Administrator.

"Effective Date" shall have the meaning set forth in the Adoption Agreement.

"Eligible Deferred Compensation Plan" means a plan maintained by any employer that constitutes an "eligible deferred compensation plan" within the meaning of Code section 457 and that has at all relevant times included the deferral limitations set forth in section 457(b).

"Eligible Employee" means any Employee employed by or performing services for the Company, subject to the modifications and exclusions described in the Adoption Agreement. If the Plan is not a Governmental Plan, it is intended that

participation in the Plan be limited to a select group of management or highly compensated employees within the meaning of Title 1 of the Employee Retirement Income Security Act. If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the Company is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Company in settlement of any claim or action relating to such individual's employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination.

An individual who becomes employed by the Employer in a transaction between the Employer and another entity that is a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of the trade or business shall not become eligible to participate in the Plan until the Plan Sponsor specifically authorizes such participation.

"Employee" means (i) any individual who is employed by the Employer and (ii) any independent contractor who performs services for the Employer within the meaning of Treas. Reg. 1.457-(2)(e). Effective for Plan Years beginning after December 31, 2008, a Participant receiving differential wage payments (as defined in Code section 3401(h)(2)) shall be treated as an Employee of the Employer making the payment pursuant to Code section 414(u)(12), Notice 2010-5 and any superseding guidance.

"Employer" means the Company or any other employer required to be aggregated with the Company under Code sections 414(b), (c), (m) or (o); provided, however, that "Employer" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above. An Employer is limited to an entity that is a State or a Tax-Exempt Entity. The term "Employer" does not include a church as defined in Code section 3121(w)(3)(A), a qualified church-controlled organization as defined in Code section 3121(w)(3)(B), or the Federal government or any agency or instrumentality thereof.

"ERISA" means the Employee Retirement Income Security Act of 1974, all amendments thereto and all federal regulations promulgated pursuant thereto.

"Governmental Plan" means a Plan maintained by a State. The Plan shall be considered to be a Governmental Plan only to the extent provided in the Adoption Agreement.

"Includible Compensation" means, with respect to the taxable year, the Participant's compensation, as defined in Code section 415(c)(3). Includible Compensation shall be determined without regard to any community property laws.

"Normal Retirement Age" shall have the meaning set forth in the Adoption Agreement. For purposes of the special Code section 457 catch-up in Section 5.02(c), an entity sponsoring more than one eligible plan may not permit a Participant to have more than one Normal Retirement Age under the eligible plans it sponsors.

"Participant" means an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

"Plan Administrator" means the person(s) designated pursuant to the Adoption Agreement and Section 7.01.

"Plan Sponsor" means the entity described in the Adoption Agreement.

"Plan Year" means the 12-consecutive month period described in the Adoption Agreement.

"Pre-tax Deferral" means Deferrals that are not includible in the Participant's gross income at the time deferred.

"Pre-tax Deferral Account" means so much of a Participant's Account as consists of a Participant's Pre-Tax Deferrals (and corresponding earnings) made to the Plan.

"Required Beginning Date" means April 1st of the calendar year following the calendar year of a Participant's attainment of age 70-1/2 or Termination, whichever is later.

"Roth Deferral" means an Deferral that is: (a) designated irrevocably by the Participant at the time of the cash or deferred election as a Roth Deferral that is being made in lieu of all or a portion of the Pre-tax Deferrals the Participant is otherwise eligible to make under the Plan; and (b) treated by the Company as includible in the Participant's income at the time the Participant would have received that amount in cash if the Participant had not made a cash or deferred election. Except as otherwise provided, Roth Deferrals shall be subject to the same conditions and limitations as apply to Deferrals.

"Roth Deferral Account" means so much of a Participant's Account as consists of a Participant's Roth Deferrals (and corresponding earnings) made to the Plan. The Plan will maintain a record of the amount of Roth Deferrals in each Participant's Roth Deferral Account.

"State" means a state (treating the District of Columbia as a state as provided under Code section 7701(a)(10)), a political subdivision of a state, and any agency or instrumentality of a state.

"Tax-Exempt Entity" means includes any organization exempt from tax under subtitle A of the Internal Revenue Code, except that a governmental unit (including an international governmental organization) is not a tax-exempt entity.

"Termination" and "Termination of Employment" means:

(a) Employee. The cessation of an Employee's active employment with an Employer.

(b) Independent Contractor. An independent contractor is considered to have a Termination upon the expiration of the contract (or in the case of more than one contract, all contracts) under which services are performed if the expiration constitutes a good-faith and complete termination of the contractual relationship.

"Trust Agreement" means in the case of a Governmental Plan, the written agreement (or declaration) made by and between the Employer and the Trustee under which the Trust Fund is maintained.

"Trust Fund" means in the case of a Governmental Plan, the trust fund or custodial account (to the extent permitted under Code section 457(g) and Treas. Reg. section 1.457-8) created under and subject to the Trust Agreement.

"Trustee" means in the case of a Governmental Plan, the trustee or custodian duly appointed and currently serving under the Trust Agreement. In the case of a Plan maintained by a Tax-Exempt Entity, the trustee duly appointed and currently serving under the grantor trust.

"Valuation Date" shall have the meaning set forth in the Adoption Agreement.

ARTICLE 3 PARTICIPATION

Section 3.01 PARTICIPATION

Each Eligible Employee as of the Effective Date who was eligible to participate in the Plan immediately prior to the Effective Date shall be a Participant eligible to participate in the Plan pursuant to Article 4 on the Effective Date. Each other Eligible Employee who was not a Participant in the Plan prior to the Effective Date shall become a Participant eligible to participate pursuant to Article 4 on the date specified in the Adoption Agreement; provided that he is an Eligible Employee on such date.

Section 3.02 TRANSFERS/TERMINATIONS

If a change in job classification, Termination or a transfer results in an individual no longer qualifying as an Eligible Employee, such Employee shall cease to be a Participant for purposes of Articles 4 and 5 (or shall not become eligible to become a Participant) as of the first day of the month immediately succeeding such change of job classification or transfer; or in the case of a Termination, the effective date of the Termination. Should such Employee again qualify as an Eligible Employee or if an Employee who was not previously an Eligible Employee becomes an Eligible Employee, he shall become a Participant on the first day of the month following the later of the effective date of such subsequent change of status or the date the Employee meets the eligibility requirements of this Article 3.

Section 3.03 PROCEDURES FOR ADMISSION

The Plan Administrator shall prescribe such forms and may require such data from Participants as are reasonably required to enroll a Participant in the Plan or to effectuate any Participant elections. The Plan Administrator may impose other limitations and/or conditions with respect to participation in the Plan on Eligible Employees who commence or recommence participation in the Plan pursuant to Section 3.02.

ARTICLE 4 ELECTIONS

Section 4.01 DEFERRAL ELECTIONS

This Section shall apply only to the extent that the Adoption Agreement permits Participant Deferrals.

(a) Compensation. A Deferral Agreement shall become effective no earlier than the later of the Effective Date or first day of the calendar month following the month in which the agreement is made. A new Employee may defer Compensation payable in the calendar month during which the Participant first becomes an Employee if an agreement providing for the Deferral is entered into on or before the first day on which the Participant performs services for the Employer.

(b) Roth Deferrals. If the Plan is a Governmental Plan and to the extent provided in the Adoption Agreement, Participants shall be eligible to irrevocably designate some or all of their Deferrals as either Pre-tax Deferrals or Roth Deferrals. All elections shall be subject to the same election procedures, limits on modifications and other terms and conditions on elections as specified in the Plan. If Roth Deferrals are not permitted, all Deferrals shall be designated as Pre-tax Deferrals.

(c) Sick, Vacation and Back Pay. To the extent provided in the Adoption Agreement, a Participant may also defer accumulated sick pay, accumulated vacation pay, and back pay. Such elections may be deferred for any calendar month only if an agreement providing for the Deferral is entered into before the beginning of the month in which the amounts would otherwise be paid or made available and the Participant is an Employee on the date the amounts would otherwise be paid or made available. For purposes of section 457, Compensation that would otherwise be paid for a payroll period that begins before severance from employment is treated as an amount that would otherwise be paid or made available before an Employee has a severance from employment.

Section 4.02 ELECTION PROCEDURES

Each Participant may execute elections pursuant to this Article 4 in the form and manner prescribed by the Plan Administrator. The Plan Administrator shall provide each Participant with the forms necessary to make such elections. Notwithstanding the foregoing, a Participant shall be eligible to make elections only to the extent such elections are permitted in the Adoption Agreement and relate to contributions and/or benefits for which the Participant has met the eligibility requirements of Article 3. The Adoption Agreement may provide additional conditions and/or limitations on Participant elections.

ARTICLE 5 ACCOUNTS/BENEFITS

Section 5.01 ESTABLISHMENT OF ACCOUNTS

(a) Accounts. The Plan Administrator shall establish and maintain a book entry account on behalf of each Participant to the extent necessary to account for benefits provided hereunder. Each such book entry account shall reflect the aggregate of Participant and/or Company contributions and investment experience attributable to each such book entry account based upon the investment experience/plan expenses described in Section 5.05 below. Each book entry account shall also reflect any reductions due to expense charges applied to, and distributions made from, each such account. If the Plan is not a Governmental Plan, such account(s) shall be simply an unsecured claim against the general assets of the Company and a Participant shall have no interest in such account, which is established merely as an accounting convenience. For purposes of this Subsection, "Participant" shall mean an Eligible Employee who has met the eligibility requirements of Article 3.

(b) Employer Contributions. To the extent provided in the Adoption Agreement, the Company may, in its sole discretion, make additional credits to the Account of any Participant either as matching or other non-elective contributions. Except as otherwise provided, any such additional credits shall be treated as Deferrals for all purposes of the Plan. Deferrals may be made for former Employees with respect to compensation described in § 1.415(c)-2(e)(3)(ii) (relating to certain compensation paid within 2-1/2 months following severance from employment), compensation described in § 1.415(c)-2(g)(4) (relating to compensation paid to Participants who are permanently and totally disabled), and compensation relating to qualified military service under section 414(u).

(c) Contribution to Trust Fund. If the Plan is a Governmental Plan, Deferrals by the Participant under the Plan shall be transferred to the Trust Fund within a period that is not longer than is reasonable for the proper administration of the Participant's Account. For this purpose, Deferrals shall be treated as contributed within a period that is not longer than is reasonable for the proper administration if the contribution is made to the Trust Fund within 15 business days following the end of the month in which the amount would otherwise have been paid to the Participant. Effective as provided in Internal Revenue Service Revenue Ruling 2011-1 (as modified by Revenue Service Notice 2012-6 and any superseding guidance), to the extent that the Plan's trust is a part of any group trust (within the meaning of Internal Revenue Service Revenue Rulings 81-100 and 2011-1), such group trust may invest in the accounts and plans described in Internal Revenue Service Revenue Ruling 2011-1; provided, that requirements of such ruling and superseding guidance are met.

(d) USERRA. An Employee whose employment is interrupted by qualified military service under Code section 414(u) or who is on a leave of absence for qualified military service under Code section 414(u) may elect to make additional Deferrals and receive allocations of Company contributions, if any, upon resumption of employment with the Employer equal to the maximum Deferrals that the Employee could have elected during that period (or received if Company contributions) if the Employee's employment with the Employer had continued (at the same level of Compensation) without the interruption or leave, reduced by the Deferrals, if any, actually made for the Employee during the period of the interruption or leave. This right applies for five years following the resumption of employment (or, if sooner, for a period equal to three times the period of the interruption or leave).

Section 5.02 LIMITATIONS

(a) General Limitation. Except as provided in Subsection (b) and (c), a Participant's Deferrals for a taxable year shall not exceed the lesser of:

(1) $15,000 (or such greater dollar limit as may be in effect under Code section 457(e)); or

(2) One hundred percent (100%) of the Participant's Includible Compensation for the calendar year.

(b) Age 50 Catch-Up. If the Plan is a Governmental Plan, a Participant who will attain age 50 or more by the end of the calendar year is permitted to elect an additional amount of Deferrals pursuant to Code section 414(v), up to the maximum

age 50 catch-up amount for the year. The maximum dollar amount of the age 50 catch-up Deferrals for a year is $5,000, adjusted for cost-of-living after 2006 to the extent provided under the Code. The Age 50 Catch-up described in this Subsection does not apply for any taxable year for which a higher limitation applies under the special Code section 457 catch-up under Section 5.02(c).

(c) Catch-up Limitation. If the applicable year is one of a Participant's last 3 calendar years ending before the year in which the Participant attains Normal Retirement Age and the amount determined under this Subsection (c) exceeds the amount computed under Subsection (a) and if a Governmental Plan Subsection (b), then the annual Deferral limit under this Section 5.02 shall be the lesser of:

(1) An amount equal to 2 times the Subsection (a)(1) applicable dollar amount for such year; or

(2) The sum of:

(A) An amount equal to (x) the aggregate Subsection (a) limit for the current year plus each prior calendar year beginning after December 31, 2001 during which the Participant was an Eligible Employee under the Plan, minus (y) the aggregate amount of Compensation that the Participant deferred under the Plan during such years, plus

(B) An amount equal to (x) the aggregate limit referred to in Code section 457(b)(2) for each prior calendar year beginning after December 31, 1978 and before January 1, 2002 during which the Participant was an Eligible Employee, minus (y) the aggregate contributions to Pre-2002 Coordination Plans for such years.

The amounts under this Subsection 5.02(c) shall be determined in accordance with Treas. Reg. section 1.457-4(c)(3).

(d) Participant Covered By More Than One Eligible Plan. If the Participant is or has been a participant in one or more other eligible plans within the meaning of section 457(b) of the Code, then this Plan and all such other plans shall be considered as one plan for purposes of applying the foregoing limitations of this Section 5.02. For this purpose, the Plan Administrator shall take into account any other such eligible plan maintained by the Employer and shall also take into account any other such eligible plan for which the Administrator receives from the Participant sufficient information concerning his or her participation in such other plan.

(e) Pre-Participation Years. In applying Subsection (c), a year shall be taken into account only if (i) the Participant was eligible to participate in the Plan during all or a portion of the year and (ii) Compensation deferred, if any, under the Plan during the year was subject to the basic annual limitation described in Subsection (a) or any other plan ceiling required by section 457(b) of the Code.

(f) Pre-2002 Coordination Plans. For purposes of Subsection (c)(2)(B)(y), "contributions to Pre-2002 Coordination Plans" means any employer contribution, salary reduction or elective contribution under any other eligible Code section 457(b) plan, or a salary reduction or elective contribution under any Code section 401(k) qualified cash or deferred arrangement, Code section 402(h)(1)(B) simplified employee pension (SARSEP), Code section 403(b) annuity contract, and Code section 408(p) simple retirement account, or under any plan for which a deduction is allowed because of a contribution to an organization described in section 501(c)(18) of the Code, including plans, arrangements or accounts maintained by the Employer or any employer for whom the Participant performed services. However, the contributions for any calendar year are only taken into account for purposes of Subsection (c)(2)(B)(y) to the extent that the total of such contributions does not exceed the aggregate limit referred to in section 457(b)(2) of the Code for that year.

(g) Disregard Excess Deferral. For purposes of Subsections (a), (b) and (c), an individual is treated as not having deferred compensation under a plan for a prior taxable year to the extent excess Deferrals under the Plan are distributed, as described in Subsection (h). To the extent that the combined deferrals for pre-2002 years exceeded the maximum deferral limitations, the amount is treated as an excess Deferral for those prior years.

(h) Correction of Excess Deferrals. If the annual Deferral on behalf of a Participant for any calendar year exceeds the limitations described above, or the annual Deferral on behalf of a Participant for any calendar year exceeds the limitations described above when combined with other amounts deferred by the Participant under another eligible deferred compensation

plan under Code section 457(b) for which the Participant provides information that is accepted by the Plan Administrator, then the annual Deferral, to the extent in excess of the applicable limitation (adjusted for any income or loss in value, if any, allocable thereto), shall be distributed to the Participant as soon as administratively feasible. If the annual Deferral made on behalf of a Participant for any calendar year exceeds the limitations described above and the Plan is not a Governmental Plan the excess (adjusted for any income or loss in value, if any, allocable thereto), shall be distributed to the Participant no later than April 15 of the subsequent taxable year. If the vesting of a Participant's Account pursuant to Section 5.06 may cause the limitations of this Section to be exceeded, the Plan Administrator may elect to defer such vesting and/or refund or reduce Deferrals.

Section 5.03 TRANSFERS

This Section shall apply to the extent that the Adoption Agreement permits transfers from Eligible Deferred Compensation Plans. At the direction of the Company, the Plan Administrator may accept a transfer of assets to the Plan as provided in this Section. Such a transfer is permitted only if the other plan provides for such direct transfer. The Plan Administrator may require in its sole discretion that the transfer be in cash or other property acceptable to the Plan Administrator and may require such documentation from the other plan as it deems necessary to effectuate the transfer. A transfer shall only be permitted to the extent that it is permissible in accordance with Code section 457(e)(10) and Treas. Reg. section 1.457-10(b).

Section 5.04 GOVERNMENTAL PLAN ROLLOVERS

This Section shall apply only to the extent that the Plan is a Governmental Plan and the Adoption Agreement permits rollovers.

(a) In General. A Participant (or in the discretion of the Plan Administrator an Eligible Employee) who is an Employee and who is entitled to receive an eligible rollover distribution from another eligible retirement plan may request to have all or a portion of the eligible rollover distribution paid to the Plan. The Plan Administrator may require such documentation from the distributing plan as it deems necessary to effectuate the rollover in accordance with Code section 402 and to confirm that such plan is an eligible retirement plan within the meaning of Code section 402(c)(8)(B).

To the extent permitted by the Plan Administrator, to the extent the Plan permits Roth Deferrals and to the extent permitted by Code section 402A(c), Notice 2010-84 and any superseding guidance, a distribution from the Plan other than from a designated Roth Account that is an eligible rollover distribution (as defined in Code section 408A(e)) may be rolled over to a designated Roth Account maintained under this Plan for the benefit of the individual to whom the distribution is made.

(b) Eligible Rollover Distribution.

(1) For purposes of Subsection (a), an eligible rollover distribution means any distribution of all or any portion of a Participant's benefit under another eligible retirement plan, except that an eligible rollover distribution does not include (A) any installment payment for a period of 10 years or more, (B) any distribution made as a result of an unforeseeable emergency or other distribution which is made upon hardship of the employee, or (C) for any other distribution, the portion, if any, of the distribution that is a required minimum distribution under Code section 401(a)(9).

(2) In addition, an eligible retirement plan means an individual retirement account described in Code section 408(a), an individual retirement annuity described in Code section 408(b), a qualified trust described in Code section 401(a), an annuity plan described in Code section 403(a) or 403(b), or an eligible governmental plan described in Code section 457(b), that accepts the eligible rollover distribution.

(3) If the Plan permits Roth Deferrals, the Plan may accept a rollover contribution to a Roth Deferral Account only if it is a direct rollover from another Roth deferral account under an applicable retirement plan described in Code section 402A(e)(1) and only to the extent the rollover is permitted under the rules of Code section 402(c).

(c) Separate Accounting. The Plan shall establish and maintain for the Participant a separate Account for any eligible rollover distribution paid to the Plan from any eligible retirement plan that is not an eligible governmental plan under

Code section 457(b). In addition, the Plan shall establish and maintain for the Participant a separate Account for any eligible rollover distribution paid to the Plan from any eligible retirement plan that is an eligible governmental plan under Code section 457(b).

Section 5.05 EARNINGS/EXPENSES

(a) Earnings. A Participant's Accounts shall be credited with earnings in the manner specified in the Adoption Agreement. The Plan Administrator shall credit investment experience to each Participant's Account as of each Valuation Date specified in the Adoption Agreement. Except as provided in Subsection (c), if the Adoption Agreement provides for predetermined investments, such investments are to be used for measurement purposes only and there is no obligation for the Plan Administrator or Company to set aside, fund or actually purchase any investments.

(b) Expenses. The expenses of administering the Plan, including (i) expenses incurred by the Plan Administrator in the administration of the Plan, (ii) fees and expenses approved by the Plan Administrator for investment advisory, custodial, recordkeeping, and other plan administration and communication services, and (iii) any other expenses or charges allocable to the Plan that have been approved by the Plan Administrator may be charged, at the discretion of the Plan Administrator, to Participants' Account balances. If amounts are deposited into an account or trust owned by the Employer, brokerage fees, transfer taxes, and any other costs incident to the purchase or sale of securities or other investments shall be deemed to be part of the cost of such securities or investments or deducted in computing the sales proceeds therefrom and shall be accounted for accordingly.

(c) Governmental Plan. If the Plan is a Governmental Plan, the earnings/losses shall be determined with respect to the Participant's allocable share of the earnings and losses of the Trust Fund.

Section 5.06 VESTING

(a) A Participant shall have a fully vested and nonforfeitable interest in his Accounts relating to Participant contributions.

(b) Subject to the provisions of Section 5.02(h), the Participant's interest in his Accounts relating to Company contributions shall vest based on his years of vesting service in accordance with the terms of the Adoption Agreement.

For purposes of the Adoption Agreement, "3-7 Year Graded", "2-6 Year Graded", "1-5 Year Graded", "1-4 Year Graded", "5 Year Cliff", "3 Year Cliff" and "2 Year Cliff" shall be determined in accordance with the following schedules:

	Years of Vesting Service	Vesting Percentage
"3-7 Year Graded":		
	Less than Three Years	0%
	Three Years but less than Four Years	20%
	Four Years but less than Five Years	40%
	Five Years but less than Six Years	60%
	Six Years but less than Seven Years	80%
	Seven or More Years	100%
"2-6 Year Graded":		
	Less than Two Years	0%
	Two Years but less than Three Years	20%
	Three Years but less than Four Years	40%
	Four Years but less than Five Years	60%
	Five Years but less than Six Years	80%
	Six or More Years	100%

"1-5 Year Graded":

Less than One Year	0%
One Year but less than Two Years	20%
Two Years but less than Three Years	40%
Three Years but less than Four Years	60%
Four Years but less than Five Years	80%
Five or More Years	100%

"1-4 Year Graded":

Less than One Year	0%
One Year but less than Two Years	25%
Two Year but less than Three Years	50%
Three Years but less than Four Years	75%
Four or More Years	100%

"5 Year Cliff":

Less than Five Years	0%
Five or More Years	100%

"3 Year Cliff":

Less than Three Years	0%
Three or More Years	100%

"2 Year Cliff":

Less than Two Years	0%
Two or More Years	100%

In addition, the Adoption Agreement may provide that a Participant will become fully (100%) vested upon: (i) his attainment of Normal Retirement Age while an Employee, (ii) his death while an Employee, (iii) his suffering a disability while an Employee, or (iv) other event as specified in the Adoption Agreement.

(c) Special Forfeitures. Notwithstanding any provision to the contrary, a Participant shall also forfeit his or her Account pursuant to any special forfeiture provisions in the Adoption Agreement. Such special forfeiture provisions may include, without limitation, a provision requiring complete forfeiture of Participant's Account upon the occurrence of a specified event.

Section 5.07 FORFEITURES

(a) Non Governmental Plan. If the Plan is not a Governmental Plan, all forfeitures shall revert to the Company.

(b) Governmental Plan. If the Plan is a Governmental Plan, forfeitures shall be used to reduce Company contributions or to pay Plan expenses.

ARTICLE 6 DISTRIBUTIONS

Section 6.01 TIME OF DISTRIBUTION

(a) Non Governmental Plan. If the Plan is not a Governmental Plan and except as provided in Sections 6.03 and 6.04, benefits shall commence no earlier than the sixty-first (61st) day following: (i) the date of the Participant's Termination or, (ii) if earlier and so provided in the Adoption Agreement, the date the Participant attains age 70-1/2. Not later than sixty (60) days following the date the Participant becomes eligible to commence distributions, the Participant may elect a commencement date for all of the Participant's Account balance. A Participant's election of a benefit commencement date under this Section shall be irrevocable, provided, however, the Participant may, at least 30 days prior to such commencement date, elect a deferred commencement date as permitted under Code section 457(e)(9)(B). Any Participant who has made such a second election of a deferred commencement date may not thereafter revoke or modify that election. Benefits may not commence later than the date specified in the Adoption Agreement.

(b) Governmental Plan. If the Plan is a Governmental Plan and except as provided in Sections 6.03, 6.04 and 6.07, upon (i) Termination or (ii) if earlier and so provided in the Adoption Agreement, the date the Participant attains age 70-1/2, a Participant shall be entitled to receive a distribution of his or her Account under any form of distribution permitted under Section 6.02 commencing at the date elected by the Participant. Benefits may not commence later than the date specified in the Adoption Agreement.

(c) Participants Receiving Differential Wage Payments During Service in the Uniformed Service. A Participant receiving differential wage payments (as defined in Code section 3401(h)(2)) shall be treated as having Terminated from employment during any period of services described in Code section 3401(h)(2)(A). If a Participant elects to receive a distribution by reason of this paragraph, the Participant may not make a Participant Contribution during the 6-month period beginning on the date of distribution.

(d) Ordering Rule. The Plan Administrator shall determine the ordering rule for distributions; provided that such ordering rule is nondiscriminatory. Such ordering rule may provide that the Participant or Beneficiary may elect to have payments made first or last from his Roth Deferral Account and any other Account.

Section 6.02 FORM OF DISTRIBUTION

(a) In General. A Participant's benefit under the Plan may only be paid in the forms and medium specified in the Adoption Agreement and permitted under Code section 457 and regulations promulgated thereunder. No election of a distribution form under this Section may be made or changed after the commencement date for such distribution form. If an election is not made prior to the date benefits commence under Section 6.01, distributions shall be made in a single lump sum payment as soon as practicable thereafter.

(b) Limitations. No distribution option may be selected by a Participant or Beneficiary under this Article 6 unless it satisfies the requirements of Code sections 401(a)(9) and 457(d).

(c) Cash Outs. The Plan Administrator reserves the right to adopt guidelines under which Account balances below a specified level may be distributed in a lump sum upon Termination or at a deferred commencement date and to establish minimum amounts of installment payments.

Section 6.03 SMALL DISTRIBUTIONS

To the extent provided in the Adoption Agreement, the Plan Administrator reserves the right, subject to the limitations of Code section 457(e)(9)(A), to establish uniform guidelines under which all or a portion of a Participant's Account balances may be distributed in a lump sum before the Participant's Termination, and either with or without the Participant's consent,

provided that (i) the amount of the distribution does not exceed $5,000 (or the dollar limit under Code section 411(a)(11), if greater), (ii) no Deferral has been credited to the Participant's Account in the preceding twenty-four (24) months, and (iii) no prior payment has been made to the Participant under this Section.

Section 6.04 UNFORESEEABLE EMERGENCIES

(a) In General. If the Participant has an unforeseeable emergency before retirement or other Termination, the Participant may elect to receive a lump sum distribution equal to the amount requested or, if less, the maximum amount determined by the Plan Administrator to be permitted to be distributed under this Section.

(b) Unforeseeable Emergency Defined. An unforeseeable emergency is defined as a severe financial hardship of the Participant resulting from:

(1) an illness or accident of the Participant, the Participant's spouse, the Participant's Beneficiary, or the Participant's dependent (as defined in Code section 152 determined without regard to Code section 152(b)(1), (b)(2) and (d)(1)(B));

(2) loss of the Participant's property due to casualty (including the need to rebuild a home following damage to a home not otherwise covered by homeowner's insurance, e.g., as a result of a natural disaster);

(3) the need to pay for the funeral expenses of the Participant's spouse, Beneficiary or dependent (as defined in Code section 152 determined without regard to Code section 152(b)(1), (b)(2) and (d)(1)(B));

(4) or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant.

For example, the imminent foreclosure of or eviction from the Participant's primary residence may constitute an unforeseeable emergency. In addition, the need to pay for medical expenses, including non-refundable deductibles, the cost of prescription drug medication, and other similar situations, such as those described in Revenue Ruling 2010-27 (significant water damage from a water leak and funeral expenses for an adult child who is not a dependent; credit card debt is not considered unforeseeable), may constitute an unforeseeable emergency. Except as otherwise specifically provided in this Section, neither the purchase of a home nor the payment of college tuition is an unforeseeable emergency.

(c) Unforeseeable Emergency Distribution Standard. A distribution on account of unforeseeable emergency may not be made to the extent that such emergency is or may be relieved through reimbursement or compensation from insurance or otherwise, by liquidation of the Participant's assets, to the extent the liquidation of such assets would not itself cause severe financial hardship, or by cessation of deferrals under the Plan.

(d) Distribution Necessary to Satisfy Emergency Need. Distributions because of an unforeseeable emergency may not exceed the amount reasonably necessary to satisfy the emergency need (which may include any amounts necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated to result from the distribution).

Section 6.05 DEATH

(a) In General. Payments to the Participant's Beneficiary shall be subject to the election procedures in Section 6.01 and shall be made in the time and form specified in the Adoption Agreement.

(b) Death Benefits Under USERRA. Effective January 1, 2007, if the Adoption Agreement specifies the Plan is a Governmental Plan, and a Participant dies while performing qualified military service (as defined in Code section 414(u)), the survivors of the Participant are entitled to any additional benefits (other than benefit accruals relating to the period of qualified military service) provided under the plan had the Participant resumed and then Terminated employment on account of death

pursuant to Code section 401(a)(37), Notice 2010-5 and any superseding guidance. For example, this may include full vesting for death while an Employee under Section 5.06(b) if provided under the Adoption Agreement.

Section 6.06 WITHHOLDING

To the extent required by applicable law, income and other taxes shall be withheld from each payment, and payments shall be made reported to the appropriate governmental agency or agencies.

Section 6.07 DISTRIBUTIONS FROM ROLLOVER ACCOUNT

If the Plan is a Governmental Plan and a Participant has a separate Account attributable to rollover contributions to the Plan, the Participant may at any time elect to receive a distribution of all or any portion of the amount held in the rollover Account to the extent provided in the Adoption Agreement.

Section 6.08 TRANSFERS

This Section shall apply to the extent that the Adoption Agreement permits transfers to another Eligible Deferred Compensation Plan. At the direction of the Company, the Plan Administrator may transfer assets to the other Plan as provided in this Section. Such a transfer is permitted only if the other plan provides for such direct transfer. The Plan Administrator may require such documentation from the other plan as it deems necessary to effectuate the transfer. A transfer shall only be permitted to the extent that it is permissible in accordance with Code section 457(e)(10) and Treas. Reg. section 1.457-10(b).

Section 6.09 DIRECT ROLLOVERS - GOVERNMENTAL PLANS

(a) In General. This Section shall only apply to a Governmental Plan. A Participant, the surviving spouse of a Participant (or a Participant's former spouse who is the alternate payee under a domestic relations order, as defined in Code section 414(p)), or a non-spouse beneficiary who is entitled to an eligible rollover distribution may elect, at the time and in the manner prescribed by the Plan Administrator, to have all or any portion of the distribution paid directly to an eligible retirement plan specified by the Participant in a direct rollover. A non-spouse beneficiary must be a designated beneficiary within the meaning of Code section 401(a)(9)(E) and such direct rollovers shall be subject to the terms and conditions of IRS Notice 2007-7 and superseding guidance, including but not limited to the provision in Q&A-17 regarding required minimum distributions.

(b) Eligible Rollover Distribution. For purposes of this Section, an eligible rollover distribution means any distribution of all or any portion of a Participant's Account, except that an eligible rollover distribution does not include (1) any installment payment for a period of 10 years or more (2) any distribution made as a result of an unforeseeable emergency, or (3) for any other distribution, the portion, if any, of the distribution that is a required minimum distribution under Code section 401(a)(9). In addition, an eligible retirement plan means an individual retirement account described in Code section 408(a), an individual retirement annuity described in Code section 408(b), a qualified trust described in Code section 401(a), an annuity plan described in Code section 403(a) or 403(b), an eligible governmental plan described in Code section 457(b), or a Roth IRA (subject to Code sections 408A(c)(3)(B) and 457(e)(16)) that accepts the eligible rollover distribution.

If any portion of an eligible rollover distribution is attributable to payments or distributions from a Roth Deferral Account, an eligible retirement plan shall only include another Roth deferral account under an applicable retirement plan described in Code section 402A(e)(1) or to a Roth IRA described in Code section 408A and only to the extent the rollover is permitted under the rules of Code section 402(c).

(c) Mandatory Rollover. In the event of a mandatory distribution greater than $1,000 in accordance with the provisions of Sections 6.02 and 6.03, if the Participant does not elect to have such distribution paid directly to an eligible retirement plan specified by the Participant in a direct rollover or to receive the distribution directly, then the Plan Administrator will pay the distribution in a direct rollover to an individual retirement plan designated by the Plan Administrator.

Section 6.10 SERVICE CREDIT TRANSFERS

(a) This Section shall only apply to a Governmental Plan. If permitted in the Adoption Agreement and a Participant is also a participant in a tax-qualified defined benefit governmental plan (as defined in Code section 414(d)) that provides for the acceptance of plan-to-plan transfers with respect to the Participant, then the Participant may elect to have any portion of the Participant's Account transferred to the defined benefit governmental plan. A transfer under this Section may be made before the Participant has Terminated.

(b) A transfer may be made under Section only if the transfer is either for the purchase of permissive service credit (as defined in Code section 415(n)(3)(A)) under the receiving defined benefit governmental plan or a repayment to which Code section 415 does not apply by reason of Code section 415(k)(3).

Section 6.11 QUALIFIED HEALTH INSURANCE PREMIUMS FOR RETIRED PUBLIC SAFETY OFFICERS

If the Adoption Agreement specifies that the Plan is a Governmental Plan, the Plan Administrator may allow retired public safety officers to elect to have distributions used to pay for qualified health insurance premiums as provided in Code section 402(l). Such distributions shall be subject to the terms and conditions of IRS Notice 2007-7 and superseding guidance.

Section 6.12 DEATH OR DISABILITY DURING QUALIFIED MILITARY SERVICE

If provided in the Adoption Agreement, a Participant that dies or becomes disabled while performing qualified military service (as defined in Code section 414(u)) will be treated as if he had been employed by the Company on the day preceding death or disability and Terminated employment on the day of death or disability and receive benefit accruals related to the period of qualified military service as provided under Code section 414(u)(8), subject to paragraphs (a) and (b) below:

(a) All Participants eligible for benefits under the Plan by reason of this section shall be provided benefits on reasonably equivalent terms.

(b) For the purposes of applying Code section 414(u)(8)(C), a Participant's contributions shall be determined based on the Participant's average actual contributions for:

(1) the 12-month period of service with the Employer immediately prior to qualified military service, or

(2) if service with the Employer is less than such 12-month period, the actual length of continuous service with the employer.

Section 6.13 LOANS

(a) In General. If the Plan is a Governmental Plan and if the Adoption Agreement so provides, a Participant who is an Employee may apply for and receive a loan from his or her Account as provided in this Section. Any such loan may not be for an amount less than the minimum amount specified by the Administrator. If not specified by the Plan Administrator, the minimum loan amount shall be $1,000.

(b) Maximum Loan Amount. No loan to a Participant hereunder may exceed the lesser of: (x) $50,000, reduced by the greater of (i) the outstanding balance on any loan from the Plan to the Participant on the date the loan is made or (ii) the highest outstanding balance on loans from the Plan to the Participant during the one-year period ending on the day before the date the loan is approved by the Plan Administrator (not taking into account any payments made during such one-year period), or (y) one half of the value of the Participant's vested Account (as of the Valuation Date immediately preceding the date on which such

loan is approved by the Plan Administrator). For purposes of this Subsection, any loan from any other plan maintained by a participating employer shall be treated as if it were a loan made from the Plan, and the Participant's vested interest under any such other plan shall be considered a vested interest under this Plan; provided, however, that the provisions of this Subsection shall not be applied so as to allow the amount of a loan under this Section to exceed the amount that would otherwise be permitted in the absence of this Subsection.

(c) Terms of Loan. The terms of the loan shall:

(1) require level amortization with payments not less frequently than quarterly throughout the repayment period, except that alternative arrangements for repayment may apply in the event that the borrower is on a bona fide unpaid leave of absence for a period not to exceed one year for leaves other than a qualified military leave within the meaning of Code section 414(u) or for the duration of a leave which is due to qualified military service;

(2) require that the loan be repaid within five years unless the Participant certifies in writing to the Plan Administrator that the loan is to be used to acquire any dwelling unit which within a reasonable time is to be used (determined at the time the loan is made) as a principal residence of the Participant; and

(3) provide for interest at a rate equal to one percentage point above the prime rate as published in the *Wall Street Journal* on the first business day of the month in which the loan is approved by the Plan Administrator.

(d) Security for Loan; Default.

(1) Security. Any loan to a Participant under the Plan shall be secured by the pledge of the portion of the Participant's interest in the Plan invested in such loan.

(2) Default. In the event that a Participant fails to make a loan payment under this Section within 90 days after the date such payment is due, a default on the loan shall occur. In the event of such default, (i) all remaining payments on the loan shall be immediately due and payable, (ii) effective as of the first day of the calendar month next following the month in which any such loan default occurs, the interest rate for such loan shall be (if higher than the rate otherwise applicable) the rate being charged on loans from the Plan that are approved by the Plan Administrator in the month in which such default occurs, (iii) no contributions shall be made on such Participant's behalf prior to the first payroll period that follows by 12 calendar months the date of repayment in full of such loan, and (iv) the Participant shall be permanently ineligible for any future loans from the Plan. In the case of any default on a loan to a Participant, the Plan Administrator shall apply the portion of the Participant's interest in the Plan held as security for the loan in satisfaction of the loan on the date of Termination. In addition, the Plan Administrator shall take any legal action it shall consider necessary or appropriate to enforce collection of the unpaid loan, with the costs of any legal proceeding or collection to be charged to the Account of the Participant.

(e) Death. Notwithstanding anything elsewhere in the Plan to the contrary, in the event a loan is outstanding hereunder on the date of a Participant's death, his or her estate shall be his or her Beneficiary as to the portion of his or her interest in the Plan invested in such loan (with the Beneficiary or Beneficiaries as to the remainder of his or her interest in the Plan to be determined in accordance with otherwise applicable provisions of the Plan).

(f) Repayment. The Participant may be required, as a condition to receiving a loan, to enter into an irrevocable agreement authorizing the Employer to make payroll deductions from his or her Compensation as long as the Participant is an Employee and to transfer such payroll deduction amounts to the Trustee in payment of such loan plus interest. Repayments of a loan shall be made by payroll deduction of equal amounts (comprised of both principal and interest) from each paycheck, with the first such deduction to be made as soon as practicable after the loan funds are disbursed; provided however, that a Participant may prepay the entire outstanding balance of his loan at any time (but may not make a partial prepayment); and provided, further, that if any payroll deductions cannot be made in full because a Participant is on an unpaid leave of absence or is no longer employed by a participating employer (that has consented to make payroll deductions for this purpose) or the Participant's paycheck is insufficient for any other reason, the Participant shall pay directly to the Plan the full amount that would have been deducted from the Participant's paycheck, with such payment to be made by the last business day of the calendar month in which the amount would have been deducted.

Section 6.14 REFUNDS/INDEMNIFICATION

If the Plan Administrator determines that any person has directly or indirectly received excess payments under the Plan, the Plan Administrator shall notify such person and such person shall repay such excess amount as soon as possible, but in no event later than 30 days after the date of notification. A person receiving excess payments shall indemnify and reimburse the Company for any liability the Company may incur for making such payments. If a person fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset the person's salary or wages, and/or (ii) offset other benefits payable hereunder.

Section 6.15 CLAIMS PROCEDURE

(a) If the Adoption Agreement specifies that the Plan is a Governmental Plan, claims procedures shall be established by the policies and procedures of the Plan Administrator and/or Company and any other applicable law.

(b) If the Adoption Agreement specifies that the Plan maintained by a tax-exempt entity, claims procedures shall be established by the policies and procedures of the Plan Administrator and/or Company in conformance with ERISA section 503 and comply with the provisions below.

(1) Application for Benefits. A Participant or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim shall be in writing and shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

(2) Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days (45 days if the claim relates to a disability determination) after receipt of the claim. This period may be extended one time by the Plan for up to 90 days (30 additional days if the claim relates to a disability determination), provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial review period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the claim relates to a disability determination, the period for making the determination may be extended for up to an additional 30 days if the Plan Administrator notifies the Claimant prior to the expiration of the first 30-day extension period.

(3) Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

(4) Appeals of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day (180th day if the claim relates to a disability determination) after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall ordinarily rule on an appeal within 60 days (45 days if the claim relates to a disability determination). However, if special circumstances require an extension and the Plan Administrator furnishes the Claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days (90 days if the claim relates to a disability determination) to rule on an appeal.

(5) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.

(6) Determinations of Disability. If the claim relates to a disability determination, determinations of the Plan Administrator shall include the information required under applicable United States Department of Labor regulations.

Section 6.16 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment shall fully discharge the Plan Administrator and the Company from further liability on account thereof.

Section 6.17 MISSING PAYEE

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

Section 6.18 2009 REQUIRED MINIMUM DISTRIBUTIONS

Notwithstanding other provisions of the Plan to the contrary; to the extent provided by the Adoption Agreement and by Code section 401(a)(9), IRS Notice 2009-82 and any superseding guidance, a participant or beneficiary who would have been required to receive 2009 RMDs or Extended 2009 RMDs will receive those distributions for 2009 unless the participant or beneficiary chooses not to receive such distributions. Participants and beneficiaries described in the preceding sentence will be given the opportunity to elect to stop receiving the distributions described in the preceding sentence.

(a) In addition, notwithstanding other provisions of the Plan to the contrary, and solely for purposes of applying the direct rollover provisions of the Plan, certain additional distributions in 2009, as chosen above, will be treated as eligible rollover distributions.

(b) Definitions:

(1) "2009 RMDs" are required minimum distributions for 2009 but for the enactment of section 401(a)(9)(H) of the Code;

(2) "Extended 2009 RMDs" are one or more payments in a series of substantially equal distributions (that include the 2009 RMDs) made at least annually and expected to last for the life (or life expectancy) of the participant, the joint lives (or joint life expectancy) of the participant and the participant's designated beneficiary, or for a period of at least 10 years.

ARTICLE 7 PLAN ADMINISTRATION

Section 7.01 PLAN ADMINISTRATOR

(a) Designation. The Plan Administrator shall be specified in the Adoption Agreement. In the absence of a designation in the Adoption Agreement, the Plan Sponsor shall be the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be Employees appointed by the Plan Sponsor and the Committee shall elect a chairman and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents in its behalf.

(b) Authority and Responsibility of the Plan Administrator. The Plan Administrator shall be the Plan "administrator" as such term is defined in section 3(16) of ERISA, and as such shall have total and complete discretionary power and authority:

(i) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(ii) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 6;

(iii) to determine the amount and manner of any allocations and/or benefit accruals hereunder;

(iv) to maintain and preserve records relating to Participants, former Participants, and their Beneficiaries and alternate payees;

(v) to prepare and furnish to Participants, Beneficiaries and alternate payees all information and notices required under applicable law or the provisions of this Plan;

(vi) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(vii) to approve and enforce any loan hereunder including the repayment thereof;

(viii) to provide directions to the trustee of a trust established in conjunction with this Plan (if any) with respect to timing and methods of benefit payment, valuations at dates other than regular valuation dates and on all other matters where called for in the Plan or requested by the trustee;

(ix) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(x) to determine all questions of the eligibility of Employees and of the status of rights of Participants, Beneficiaries and alternate payees;

(xi) to adjust Accounts in order to correct errors or omissions;

(xii) to determine the status and effect of any domestic relations order and to take such action as the Plan Administrator deems appropriate in light of such domestic relations order;

(xiii) to retain records on elections and waivers by Participants, their spouses and their Beneficiaries and alternate payees;

(c) Procedures. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan, including but not limited to, procedures relating to requirements for advance notice of any election or modification of an election, minimum and maximum amount of contributions, the types of compensation that may be deferred, the minimum amounts or percentages that may be allocated among investment options, and the timing and frequency of changes to investment elections. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) Allocation of Duties and Responsibilities. The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) Compensation. The Plan Administrator shall serve without compensation for its services.

(f) Expenses. All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Company.

(g) Allocation of Fiduciary Duties. A Plan fiduciary shall have only those specific powers, duties, responsibilities and obligations as are explicitly given him under the Plan. It is intended that each fiduciary shall not be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

Section 7.02 FUNDED STATUS

(a) Unfunded Plan. This Subsection applies if the Plan is not a Governmental Plan. The Plan is intended to constitute an unfunded plan. Any amount due and payable pursuant to the terms of the Plan shall be paid out of the general assets of the Company except to the extent that it is paid from a grantor trust. All assets of the Plan shall be subject to the claims of creditors of the Company. Participants and Beneficiaries shall not have an interest in any specific asset of the Company or in any specific asset held in a grantor trust or a Company account established as a result of participation in this Plan. Except as may be provided under the terms of a grantor trust, the Company shall have no obligation to set aside any funds for the purpose of making any benefit payments under this Plan. Nothing contained herein shall give any Participant any rights that are greater than those of an unsecured creditor of the Company with respect to any unpaid amount as to which the Participant has a vested interest. No action taken pursuant to the terms of this Plan shall be construed to create a funded arrangement, a plan asset, or fiduciary relationship among the Company, its designee and a Participant or Beneficiary.

(b) Trust Fund. This Subsection applies if the Plan is a Governmental Plan.

(1) Assets Held in Trust. All contributions, all property and rights purchased with such amounts, and all income attributable to such amounts, property, or rights shall be held and invested in the Trust Fund in accordance with this Plan and the Trust Agreement. The Trust Fund, and any subtrust established under the Plan, shall be established pursuant to a written agreement. The Trustee shall ensure that all investments, amounts, property, and rights held under the Trust Fund are held for the exclusive benefit of Participants and their Beneficiaries. The Trust Fund shall be held in trust pursuant to the Trust Agreement for the exclusive benefit of Participants and their Beneficiaries and defraying reasonable expenses of the Plan and of the Trust Fund. It shall be impossible, prior to the satisfaction of all liabilities with respect to Participants and their Beneficiaries, for any part of the assets and income of the Trust Fund to be used for, or diverted to, purposes other than for the exclusive benefit of Participants and their Beneficiaries.

(2) Custodial Accounts and Annuity Contracts. For purposes of the trust requirement of this Subsection (b), custodial accounts and annuity contracts described in Code section 401(f) that satisfy the requirements of Treas. Reg. 1.457-8(a)(3) are treated as trusts under rules similar to the rules of Code section 401(f).

(3) Creditors. Except as expressly provided in the Plan, the interests of each Participant or Beneficiary under the Plan are not subject to the claims of the Participant's or Beneficiary's creditors.

(4) IRS Levy. the Plan Administrator may pay from a Participant's or Beneficiary's Account balance the amount that the Plan Administrator finds is lawfully demanded under a levy issued by the Internal Revenue Service with respect to that Participant or Beneficiary or is sought to be collected by the United States Government under a judgment resulting from an unpaid tax assessment against the Participant or Beneficiary.

(5) Mistaken Contributions. If any contribution (or any portion of a contribution) is made to the Plan by a good faith mistake of fact, then within one year after the payment of the contribution, and upon receipt in good order of a proper request approved by the Plan Administrator, the amount of the mistaken contribution (adjusted for any income or loss in value, if any, allocable thereto) shall be returned directly to the Participant or, to the extent required or permitted by the Plan Administrator, to the Employer.

Section 7.03 INDEMNIFICATION

Unless otherwise provided in the Adoption Agreement, the Company shall indemnify and hold harmless any person serving as the Plan Administrator and, if applicable, the Trustee (and their delegates) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan.

Section 7.04 COMMUNICATIONS

All enrollments, elections, designations, applications and other communications by or from an employee, Participant, Beneficiary, or legal representative of any such person regarding that person's rights under the Plan shall be made in the form and manner established by the Plan Administrator. Neither the Plan Administrator nor the Company shall be required to give effect to any such communication that is not made on the prescribed form and in the prescribed manner and that does not contain all information called for on the prescribed form.

ARTICLE 8 AMENDMENT AND TERMINATION

Section 8.01 AMENDMENT/TERMINATION

The provisions of the Plan may be amended and or terminated in writing at any time and from time to time by the Plan Sponsor. Notwithstanding the foregoing, an amendment/termination shall have no effect to the extent that it impermissibly accelerates a benefit payment or otherwise does not comply with Code section 457 and the regulations promulgated thereunder. Distributions may be made upon termination of the Plan to the extent such payments comply with Treas. Reg. section 1.457-10(a). No amendment or termination specified in this Article 8 shall result in a reduction or forfeiture of a Participant's Account unless such reduction or forfeiture is expressly provided under the terms of the Plan.

ARTICLE 9 MISCELLANEOUS

Section 9.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he may expect to receive, contingently or otherwise, under the Plan.

Section 9.02 QDRO

Notwithstanding Section 9.01, if a judgment, decree or order (including approval of a property settlement agreement) that relates to the provision of child support, alimony payments, or the marital property rights of a spouse or former spouse, child, or other dependent of a Participant is made pursuant to the domestic relations law of any state ("domestic relations order"), then the amount of the Participant's Account shall be paid in the manner and to the person or persons so directed in the domestic relations order. Such payment shall be made without regard to whether the Participant is eligible for a distribution of benefits under the Plan. The Plan Administrator shall establish reasonable procedures for determining the status of any such decree or order and for effectuating distribution pursuant to the domestic relations order.

Section 9.03 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Company and the Participant, or as a right of any Employee to continue in the employment of the Company, or as a limitation of the right of the Company to discharge any of its Employees, with or without cause.

Section 9.04 GOVERNING LAW

The Plan shall be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by Federal law.

Section 9.05 TAX EFFECT

The Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation. Furthermore, the Company does not represent or guarantee investment returns with respect to any predetermined investment options and shall not be required to restore any loss which may result from such investment or lack of investment.

Section 9.06 ASSIGNMENT

The Company may transfer, assign or encumber any of its rights, privileges, duties or obligations under this Agreement.

Section 9.07 SEVERABILITY OF PROVISIONS

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provisions had not been included.

Section 9.08 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 9.09 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

Certificate Of Completion

Envelope Id: E4799DAA-2938-45AB-9691-4DD009F6084F
Status: Completed
Subject: Please DocuSign: CHPIV 457(b) Plan- Plan Documents
Source Envelope:
Document Pages: 57
Signatures: 2
Envelope Originator:
Certificate Pages: 4
Initials: 0
EGPS Plan Documents
AutoNav: Enabled
7734 Excelsior Road, Suite 102
EnvelopeId Stamping: Enabled
Baxter, MN 56425
Time Zone: (UTC-05:00) Eastern Time (US & Canada)
documents@egps.com
IP Address: 10.101.81.73

Record Tracking

Status: Original
5/6/2025 3:18:27 PM
Holder: EGPS Plan Documents
documents@egps.com
Location: DocuSign

Signer Events	Signature	Timestamp
Lawrence E Lewis llewis@chpiv.org CEO Security Level: Email, Account Authentication (None)	DocuSigned by: Lawrence E Lewis BA8759FA977D477... Signature Adoption: Pre-selected Style Using IP Address: 174.195.196.153 Signed using mobile	Sent: 5/6/2025 5:25:23 PM Viewed: 5/6/2025 5:51:26 PM Signed: 5/14/2025 1:09:47 PM

Electronic Record and Signature Disclosure:
Accepted: 5/6/2025 5:51:26 PM
ID: 3e533c86-17b9-4a1d-9211-b1d7d46a70a3

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
Leonard Wright leonard.wright@nm.com WMA Security Level: Email, Account Authentication (None)	COPIED	Sent: 5/6/2025 5:25:24 PM Viewed: 5/6/2025 5:26:01 PM
Pam Dishong pdishong@egps.com New Business Consultant Security Level: Email, Account Authentication (None)	COPIED	Sent: 5/6/2025 5:25:24 PM Viewed: 5/14/2025 2:37:00 PM
Shannon Long slong@chpiv.org Security Level: Email, Account Authentication (None)	COPIED	Sent: 5/6/2025 5:25:24 PM Viewed: 5/6/2025 6:00:37 PM

Electronic Record and Signature Disclosure:
Not Offered via Docusign

Electronic Record and Signature Disclosure:
Not Offered via Docusign

Electronic Record and Signature Disclosure:
Not Offered via Docusign

Carbon Copy Events	Status	Timestamp

Electronic Record and Signature Disclosure:
Not Offered via Docusign

Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	5/6/2025 5:25:25 PM
Certified Delivered	Security Checked	5/6/2025 5:51:26 PM
Signing Complete	Security Checked	5/14/2025 1:09:47 PM
Completed	Security Checked	5/14/2025 1:09:47 PM

Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure

ELECTRONIC RECORD AND SIGNATURE DISCLOSURE

From time to time, Economic Group Pension Services, LLC (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through the DocuSign system. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to this Electronic Record and Signature Disclosure (ERSD), please confirm your agreement by selecting the check-box next to 'I agree to use electronic records and signatures' before clicking 'CONTINUE' within the DocuSign system.

Getting paper copies

At any time, you may request from us a paper copy of any record provided or made available electronically to you by us. You will have the ability to download and print documents we send to you through the DocuSign system during and immediately after the signing session and, if you elect to create a DocuSign account, you may access the documents for a limited period of time (usually 30 days) after such documents are first sent to you. After such time, if you wish for us to send you paper copies of any such documents from our office to you, you will be charged a $0.00 per-page fee. You may request delivery of such paper copies from us by following the procedure described below.

Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. Further, you will no longer be able to use the DocuSign system to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through the DocuSign system all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures electronically from us.

How to contact Economic Group Pension Services, LLC:

You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:
To contact us by email send messages to: kogrady@egps.com

To advise Economic Group Pension Services, LLC of your new email address

To let us know of a change in your email address where we should send notices and disclosures electronically to you, you must send an email message to us at kogrady@egps.com and in the body of such request you must state: your previous

email address, your new email address. We do not require any other information from you to change your email address.

If you created a DocuSign account, you may update it with your new email address through your account preferences.

To request paper copies from Economic Group Pension Services, LLC

To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an email to kogrady@egps.com and in the body of such request you must state your email address, full name, mailing address, and telephone number. We will bill you for any fees at that time, if any.

To withdraw your consent with Economic Group Pension Services, LLC

To inform us that you no longer wish to receive future notices and disclosures in electronic format you may:

i. decline to sign a document from within your signing session, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;

ii. send us an email to kogrady@egps.com and in the body of such request you must state your email, full name, mailing address, and telephone number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

The minimum system requirements for using the DocuSign system may change over time. The current system requirements are found here: https://support.docusign.com/guides/signer-guide-signing-system-requirements.

Acknowledging your access and consent to receive and sign documents electronically

To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please confirm that you have read this ERSD, and (i) that you are able to print on paper or electronically save this ERSD for your future reference and access; or (ii) that you are able to email this ERSD to an email address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format as described herein, then select the check-box next to ‘I agree to use electronic records and signatures’ before clicking ‘CONTINUE’ within the DocuSign system.

By selecting the check-box next to ‘I agree to use electronic records and signatures’, you confirm that:

- You can access and read this Electronic Record and Signature Disclosure; and
- You can print on paper this Electronic Record and Signature Disclosure, or save or send this Electronic Record and Disclosure to a location where you can print it, for future reference and access; and
- Until or unless you notify Economic Group Pension Services, LLC as described above, you consent to receive exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you by Economic Group Pension Services, LLC during the course of your relationship with Economic Group Pension Services, LLC.

EGPS, Inc.

BASIC PLAN DOCUMENT #457B

EGPS, INC.

TABLE OF CONTENTS

ARTICLE 1 INTRODUCTION

Section 1.01 PLAN

This document ("Basic Plan Document") and its related Adoption Agreement are intended to provide deferred compensation for Eligible Employees of the Company. This Plan is intended to constitute an "eligible deferred compensation plan" within the meaning of Code section 457(b) and, if the Plan is not a Governmental Plan, a top hat plan within the meaning of ERISA sections 201(2), 301(a)(3) and 401(a)(1). The provisions of this Plan are intended to comply with requirements of Code section 457 in form and operation and shall be interpreted in a manner consistent with such Code section and regulations or guidance promulgated pursuant thereto.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Employees of the Company on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the Company whose employment terminated prior to the Effective Date, shall be determined under the provisions of the Plan, as in effect from time to time prior to that date.

ARTICLE 2 DEFINITIONS

"Account" means the book entry account maintained with respect to each Participant pursuant to Article 5.

"Adoption Agreement" means the document executed in conjunction with this Basic Plan Document that contains the optional features selected by the Plan Sponsor.

"Beneficiary" means the person or persons designated by the Participant to receive distributions from the Participant's Account after the Participant's death. Upon enrollment, the Participant shall designate a Beneficiary to receive distributions from the Participant's Account in the event of the Participant's death. A Participant may change his or her designated Beneficiary at any time. A Participant may designate any person or persons as Beneficiaries. Unless otherwise provided in the Beneficiary designation form, each designated Beneficiary shall be entitled to equal shares of the benefits payable after the Participant's death. If the Participant fails to designate a Beneficiary, or if no designated Beneficiary survives the Participant for a period of fifteen (15) days, then the Participant's surviving spouse shall be the Beneficiary. If the Participant has no surviving spouse, or if the surviving spouse does not survive the Participant for a period of fifteen (15) days, then the estate of the Participant shall be the Beneficiary.

"Code" means the Internal Revenue Code of 1986, as amended from time to time.

"Company" means the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

"Compensation" shall have the meaning set forth in the Adoption Agreement. Compensation for an independent contractor shall include payment by the Company to the independent contractor. Effective for Plan Years beginning after December 31, 2008, Compensation shall include differential wage payments (as defined in Code section 3401(h)(2)) pursuant to Code section 414(u)(12), Notice 2010-5 and any superseding guidance.

"Deferral" means, the amount of Compensation deferred, whether by salary reduction or by employer contribution. The amount of Compensation deferred under the Plan is taken into account as an annual deferral in the taxable year of the Participant in which deferred, or, if later, the year in which the amount of Compensation deferred is no longer subject to a substantial risk of forfeiture. The term "Deferral" shall not include transfers and rollovers from another plan described in Article 5. To the extent provided in the Adoption Agreement, a Participant may also defer accumulated sick pay, accumulated vacation pay, and back pay.

If the amount of Compensation deferred under the Plan during a taxable year is not subject to a substantial risk of forfeiture, the amount taken into account as an annual deferral is not adjusted to reflect gain or loss allocable to the compensation deferred. If, however, the amount of Compensation deferred under the Plan during the taxable year is subject to a substantial risk of forfeiture, the amount of Compensation deferred that is taken into account as an annual deferral in the taxable year in which the substantial risk of forfeiture lapses must be adjusted to reflect gain or loss allocable to the Compensation deferred until the substantial risk of forfeiture lapses.

"Deferral Agreement" means the agreement between an Employer and a Participant, including any amendments thereto, which specifies the amount of Deferrals to be made by the Employee. Each Deferral Agreement or amendment thereto shall be made or confirmed in writing under procedures established by the Plan Administrator.

"Effective Date" shall have the meaning set forth in the Adoption Agreement.

"Eligible Deferred Compensation Plan" means a plan maintained by any employer that constitutes an "eligible deferred compensation plan" within the meaning of Code section 457 and that has at all relevant times included the deferral limitations set forth in section 457(b).

"Eligible Employee" means any Employee employed by or performing services for the Company, subject to the modifications and exclusions described in the Adoption Agreement. If the Plan is not a Governmental Plan, it is intended that

participation in the Plan be limited to a select group of management or highly compensated employees within the meaning of Title 1 of the Employee Retirement Income Security Act. If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the Company is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Company in settlement of any claim or action relating to such individual's employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination.

An individual who becomes employed by the Employer in a transaction between the Employer and another entity that is a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of the trade or business shall not become eligible to participate in the Plan until the Plan Sponsor specifically authorizes such participation.

"Employee" means (i) any individual who is employed by the Employer and (ii) any independent contractor who performs services for the Employer within the meaning of Treas. Reg. 1.457-(2)(e). Effective for Plan Years beginning after December 31, 2008, a Participant receiving differential wage payments (as defined in Code section 3401(h)(2)) shall be treated as an Employee of the Employer making the payment pursuant to Code section 414(u)(12), Notice 2010-5 and any superseding guidance.

"Employer" means the Company or any other employer required to be aggregated with the Company under Code sections 414(b), (c), (m) or (o); provided, however, that "Employer" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above. An Employer is limited to an entity that is a State or a Tax-Exempt Entity. The term "Employer" does not include a church as defined in Code section 3121(w)(3)(A), a qualified church-controlled organization as defined in Code section 3121(w)(3)(B), or the Federal government or any agency or instrumentality thereof.

"ERISA" means the Employee Retirement Income Security Act of 1974, all amendments thereto and all federal regulations promulgated pursuant thereto.

"Governmental Plan" means a Plan maintained by a State. The Plan shall be considered to be a Governmental Plan only to the extent provided in the Adoption Agreement.

"Includible Compensation" means, with respect to the taxable year, the Participant's compensation, as defined in Code section 415(c)(3). Includible Compensation shall be determined without regard to any community property laws.

"Normal Retirement Age" shall have the meaning set forth in the Adoption Agreement. For purposes of the special Code section 457 catch-up in Section 5.02(c), an entity sponsoring more than one eligible plan may not permit a Participant to have more than one Normal Retirement Age under the eligible plans it sponsors.

"Participant" means an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

"Plan Administrator" means the person(s) designated pursuant to the Adoption Agreement and Section 7.01.

"Plan Sponsor" means the entity described in the Adoption Agreement.

"Plan Year" means the 12-consecutive month period described in the Adoption Agreement.

"Pre-tax Deferral" means Deferrals that are not includible in the Participant's gross income at the time deferred.

"Pre-tax Deferral Account" means so much of a Participant's Account as consists of a Participant's Pre-Tax Deferrals (and corresponding earnings) made to the Plan.

"Required Beginning Date" means April 1st of the calendar year following the calendar year of a Participant's attainment of age 70-1/2 or Termination, whichever is later.

"Roth Deferral" means an Deferral that is: (a) designated irrevocably by the Participant at the time of the cash or deferred election as a Roth Deferral that is being made in lieu of all or a portion of the Pre-tax Deferrals the Participant is otherwise eligible to make under the Plan; and (b) treated by the Company as includible in the Participant's income at the time the Participant would have received that amount in cash if the Participant had not made a cash or deferred election. Except as otherwise provided, Roth Deferrals shall be subject to the same conditions and limitations as apply to Deferrals.

"Roth Deferral Account" means so much of a Participant's Account as consists of a Participant's Roth Deferrals (and corresponding earnings) made to the Plan. The Plan will maintain a record of the amount of Roth Deferrals in each Participant's Roth Deferral Account.

"State" means a state (treating the District of Columbia as a state as provided under Code section 7701(a)(10)), a political subdivision of a state, and any agency or instrumentality of a state.

"Tax-Exempt Entity" means includes any organization exempt from tax under subtitle A of the Internal Revenue Code, except that a governmental unit (including an international governmental organization) is not a tax-exempt entity.

"Termination" and "Termination of Employment" means:

(a) Employee. The cessation of an Employee's active employment with an Employer.

(b) Independent Contractor. An independent contractor is considered to have a Termination upon the expiration of the contract (or in the case of more than one contract, all contracts) under which services are performed if the expiration constitutes a good-faith and complete termination of the contractual relationship.

"Trust Agreement" means in the case of a Governmental Plan, the written agreement (or declaration) made by and between the Employer and the Trustee under which the Trust Fund is maintained.

"Trust Fund" means in the case of a Governmental Plan, the trust fund or custodial account (to the extent permitted under Code section 457(g) and Treas. Reg. section 1.457-8) created under and subject to the Trust Agreement.

"Trustee" means in the case of a Governmental Plan, the trustee or custodian duly appointed and currently serving under the Trust Agreement. In the case of a Plan maintained by a Tax-Exempt Entity, the trustee duly appointed and currently serving under the grantor trust.

"Valuation Date" shall have the meaning set forth in the Adoption Agreement.

ARTICLE 3 PARTICIPATION

Section 3.01 PARTICIPATION

Each Eligible Employee as of the Effective Date who was eligible to participate in the Plan immediately prior to the Effective Date shall be a Participant eligible to participate in the Plan pursuant to Article 4 on the Effective Date. Each other Eligible Employee who was not a Participant in the Plan prior to the Effective Date shall become a Participant eligible to participate pursuant to Article 4 on the date specified in the Adoption Agreement; provided that he is an Eligible Employee on such date.

Section 3.02 TRANSFERS/TERMINATIONS

If a change in job classification, Termination or a transfer results in an individual no longer qualifying as an Eligible Employee, such Employee shall cease to be a Participant for purposes of Articles 4 and 5 (or shall not become eligible to become a Participant) as of the first day of the month immediately succeeding such change of job classification or transfer; or in the case of a Termination, the effective date of the Termination. Should such Employee again qualify as an Eligible Employee or if an Employee who was not previously an Eligible Employee becomes an Eligible Employee, he shall become a Participant on the first day of the month following the later of the effective date of such subsequent change of status or the date the Employee meets the eligibility requirements of this Article 3.

Section 3.03 PROCEDURES FOR ADMISSION

The Plan Administrator shall prescribe such forms and may require such data from Participants as are reasonably required to enroll a Participant in the Plan or to effectuate any Participant elections. The Plan Administrator may impose other limitations and/or conditions with respect to participation in the Plan on Eligible Employees who commence or recommence participation in the Plan pursuant to Section 3.02.

ARTICLE 4 ELECTIONS

Section 4.01 DEFERRAL ELECTIONS

This Section shall apply only to the extent that the Adoption Agreement permits Participant Deferrals.

(a) Compensation. A Deferral Agreement shall become effective no earlier than the later of the Effective Date or first day of the calendar month following the month in which the agreement is made. A new Employee may defer Compensation payable in the calendar month during which the Participant first becomes an Employee if an agreement providing for the Deferral is entered into on or before the first day on which the Participant performs services for the Employer.

(b) Roth Deferrals. If the Plan is a Governmental Plan and to the extent provided in the Adoption Agreement, Participants shall be eligible to irrevocably designate some or all of their Deferrals as either Pre-tax Deferrals or Roth Deferrals. All elections shall be subject to the same election procedures, limits on modifications and other terms and conditions on elections as specified in the Plan. If Roth Deferrals are not permitted, all Deferrals shall be designated as Pre-tax Deferrals.

(c) Sick, Vacation and Back Pay. To the extent provided in the Adoption Agreement, a Participant may also defer accumulated sick pay, accumulated vacation pay, and back pay. Such elections may be deferred for any calendar month only if an agreement providing for the Deferral is entered into before the beginning of the month in which the amounts would otherwise be paid or made available and the Participant is an Employee on the date the amounts would otherwise be paid or made available. For purposes of section 457, Compensation that would otherwise be paid for a payroll period that begins before severance from employment is treated as an amount that would otherwise be paid or made available before an Employee has a severance from employment.

Section 4.02 ELECTION PROCEDURES

Each Participant may execute elections pursuant to this Article 4 in the form and manner prescribed by the Plan Administrator. The Plan Administrator shall provide each Participant with the forms necessary to make such elections. Notwithstanding the foregoing, a Participant shall be eligible to make elections only to the extent such elections are permitted in the Adoption Agreement and relate to contributions and/or benefits for which the Participant has met the eligibility requirements of Article 3. The Adoption Agreement may provide additional conditions and/or limitations on Participant elections.

ARTICLE 5 ACCOUNTS/BENEFITS

Section 5.01 ESTABLISHMENT OF ACCOUNTS

(a) Accounts. The Plan Administrator shall establish and maintain a book entry account on behalf of each Participant to the extent necessary to account for benefits provided hereunder. Each such book entry account shall reflect the aggregate of Participant and/or Company contributions and investment experience attributable to each such book entry account based upon the investment experience/plan expenses described in Section 5.05 below. Each book entry account shall also reflect any reductions due to expense charges applied to, and distributions made from, each such account. If the Plan is not a Governmental Plan, such account(s) shall be simply an unsecured claim against the general assets of the Company and a Participant shall have no interest in such account, which is established merely as an accounting convenience. For purposes of this Subsection, "Participant" shall mean an Eligible Employee who has met the eligibility requirements of Article 3.

(b) Employer Contributions. To the extent provided in the Adoption Agreement, the Company may, in its sole discretion, make additional credits to the Account of any Participant either as matching or other non-elective contributions. Except as otherwise provided, any such additional credits shall be treated as Deferrals for all purposes of the Plan. Deferrals may be made for former Employees with respect to compensation described in § 1.415(c)-2(e)(3)(ii) (relating to certain compensation paid within 2-1/2 months following severance from employment), compensation described in § 1.415(c)-2(g)(4) (relating to compensation paid to Participants who are permanently and totally disabled), and compensation relating to qualified military service under section 414(u).

(c) Contribution to Trust Fund. If the Plan is a Governmental Plan, Deferrals by the Participant under the Plan shall be transferred to the Trust Fund within a period that is not longer than is reasonable for the proper administration of the Participant's Account. For this purpose, Deferrals shall be treated as contributed within a period that is not longer than is reasonable for the proper administration if the contribution is made to the Trust Fund within 15 business days following the end of the month in which the amount would otherwise have been paid to the Participant. Effective as provided in Internal Revenue Service Revenue Ruling 2011-1 (as modified by Revenue Service Notice 2012-6 and any superseding guidance), to the extent that the Plan's trust is a part of any group trust (within the meaning of Internal Revenue Service Revenue Rulings 81-100 and 2011-1), such group trust may invest in the accounts and plans described in Internal Revenue Service Revenue Ruling 2011-1; provided, that requirements of such ruling and superseding guidance are met.

(d) USERRA. An Employee whose employment is interrupted by qualified military service under Code section 414(u) or who is on a leave of absence for qualified military service under Code section 414(u) may elect to make additional Deferrals and receive allocations of Company contributions, if any, upon resumption of employment with the Employer equal to the maximum Deferrals that the Employee could have elected during that period (or received if Company contributions) if the Employee's employment with the Employer had continued (at the same level of Compensation) without the interruption or leave, reduced by the Deferrals, if any, actually made for the Employee during the period of the interruption or leave. This right applies for five years following the resumption of employment (or, if sooner, for a period equal to three times the period of the interruption or leave).

Section 5.02 LIMITATIONS

(a) General Limitation. Except as provided in Subsection (b) and (c), a Participant's Deferrals for a taxable year shall not exceed the lesser of:

(1) $15,000 (or such greater dollar limit as may be in effect under Code section 457(e)); or

(2) One hundred percent (100%) of the Participant's Includible Compensation for the calendar year.

(b) Age 50 Catch-Up. If the Plan is a Governmental Plan, a Participant who will attain age 50 or more by the end of the calendar year is permitted to elect an additional amount of Deferrals pursuant to Code section 414(v), up to the maximum

age 50 catch-up amount for the year. The maximum dollar amount of the age 50 catch-up Deferrals for a year is $5,000, adjusted for cost-of-living after 2006 to the extent provided under the Code. The Age 50 Catch-up described in this Subsection does not apply for any taxable year for which a higher limitation applies under the special Code section 457 catch-up under Section 5.02(c).

(c) Catch-up Limitation. If the applicable year is one of a Participant's last 3 calendar years ending before the year in which the Participant attains Normal Retirement Age and the amount determined under this Subsection (c) exceeds the amount computed under Subsection (a) and if a Governmental Plan Subsection (b), then the annual Deferral limit under this Section 5.02 shall be the lesser of:

(1) An amount equal to 2 times the Subsection (a)(1) applicable dollar amount for such year; or

(2) The sum of:

(A) An amount equal to (x) the aggregate Subsection (a) limit for the current year plus each prior calendar year beginning after December 31, 2001 during which the Participant was an Eligible Employee under the Plan, minus (y) the aggregate amount of Compensation that the Participant deferred under the Plan during such years, plus

(B) An amount equal to (x) the aggregate limit referred to in Code section 457(b)(2) for each prior calendar year beginning after December 31, 1978 and before January 1, 2002 during which the Participant was an Eligible Employee, minus (y) the aggregate contributions to Pre-2002 Coordination Plans for such years.

The amounts under this Subsection 5.02(c) shall be determined in accordance with Treas. Reg. section 1.457-4(c)(3).

(d) Participant Covered By More Than One Eligible Plan. If the Participant is or has been a participant in one or more other eligible plans within the meaning of section 457(b) of the Code, then this Plan and all such other plans shall be considered as one plan for purposes of applying the foregoing limitations of this Section 5.02. For this purpose, the Plan Administrator shall take into account any other such eligible plan maintained by the Employer and shall also take into account any other such eligible plan for which the Administrator receives from the Participant sufficient information concerning his or her participation in such other plan.

(e) Pre-Participation Years. In applying Subsection (c), a year shall be taken into account only if (i) the Participant was eligible to participate in the Plan during all or a portion of the year and (ii) Compensation deferred, if any, under the Plan during the year was subject to the basic annual limitation described in Subsection (a) or any other plan ceiling required by section 457(b) of the Code.

(f) Pre-2002 Coordination Plans. For purposes of Subsection (c)(2)(B)(y), "contributions to Pre-2002 Coordination Plans" means any employer contribution, salary reduction or elective contribution under any other eligible Code section 457(b) plan, or a salary reduction or elective contribution under any Code section 401(k) qualified cash or deferred arrangement, Code section 402(h)(1)(B) simplified employee pension (SARSEP), Code section 403(b) annuity contract, and Code section 408(p) simple retirement account, or under any plan for which a deduction is allowed because of a contribution to an organization described in section 501(c)(18) of the Code, including plans, arrangements or accounts maintained by the Employer or any employer for whom the Participant performed services. However, the contributions for any calendar year are only taken into account for purposes of Subsection (c)(2)(B)(y) to the extent that the total of such contributions does not exceed the aggregate limit referred to in section 457(b)(2) of the Code for that year.

(g) Disregard Excess Deferral. For purposes of Subsections (a), (b) and (c), an individual is treated as not having deferred compensation under a plan for a prior taxable year to the extent excess Deferrals under the Plan are distributed, as described in Subsection (h). To the extent that the combined deferrals for pre-2002 years exceeded the maximum deferral limitations, the amount is treated as an excess Deferral for those prior years.

(h) Correction of Excess Deferrals. If the annual Deferral on behalf of a Participant for any calendar year exceeds the limitations described above, or the annual Deferral on behalf of a Participant for any calendar year exceeds the limitations described above when combined with other amounts deferred by the Participant under another eligible deferred compensation

plan under Code section 457(b) for which the Participant provides information that is accepted by the Plan Administrator, then the annual Deferral, to the extent in excess of the applicable limitation (adjusted for any income or loss in value, if any, allocable thereto), shall be distributed to the Participant as soon as administratively feasible. If the annual Deferral made on behalf of a Participant for any calendar year exceeds the limitations described above and the Plan is not a Governmental Plan the excess (adjusted for any income or loss in value, if any, allocable thereto), shall be distributed to the Participant no later than April 15 of the subsequent taxable year. If the vesting of a Participant's Account pursuant to Section 5.06 may cause the limitations of this Section to be exceeded, the Plan Administrator may elect to defer such vesting and/or refund or reduce Deferrals.

Section 5.03 TRANSFERS

This Section shall apply to the extent that the Adoption Agreement permits transfers from Eligible Deferred Compensation Plans. At the direction of the Company, the Plan Administrator may accept a transfer of assets to the Plan as provided in this Section. Such a transfer is permitted only if the other plan provides for such direct transfer. The Plan Administrator may require in its sole discretion that the transfer be in cash or other property acceptable to the Plan Administrator and may require such documentation from the other plan as it deems necessary to effectuate the transfer. A transfer shall only be permitted to the extent that it is permissible in accordance with Code section 457(e)(10) and Treas. Reg. section 1.457-10(b).

Section 5.04 GOVERNMENTAL PLAN ROLLOVERS

This Section shall apply only to the extent that the Plan is a Governmental Plan and the Adoption Agreement permits rollovers.

(a) In General. A Participant (or in the discretion of the Plan Administrator an Eligible Employee) who is an Employee and who is entitled to receive an eligible rollover distribution from another eligible retirement plan may request to have all or a portion of the eligible rollover distribution paid to the Plan. The Plan Administrator may require such documentation from the distributing plan as it deems necessary to effectuate the rollover in accordance with Code section 402 and to confirm that such plan is an eligible retirement plan within the meaning of Code section 402(c)(8)(B).

To the extent permitted by the Plan Administrator, to the extent the Plan permits Roth Deferrals and to the extent permitted by Code section 402A(c), Notice 2010-84 and any superseding guidance, a distribution from the Plan other than from a designated Roth Account that is an eligible rollover distribution (as defined in Code section 408A(e)) may be rolled over to a designated Roth Account maintained under this Plan for the benefit of the individual to whom the distribution is made.

(b) Eligible Rollover Distribution.

(1) For purposes of Subsection (a), an eligible rollover distribution means any distribution of all or any portion of a Participant's benefit under another eligible retirement plan, except that an eligible rollover distribution does not include (A) any installment payment for a period of 10 years or more, (B) any distribution made as a result of an unforeseeable emergency or other distribution which is made upon hardship of the employee, or (C) for any other distribution, the portion, if any, of the distribution that is a required minimum distribution under Code section 401(a)(9).

(2) In addition, an eligible retirement plan means an individual retirement account described in Code section 408(a), an individual retirement annuity described in Code section 408(b), a qualified trust described in Code section 401(a), an annuity plan described in Code section 403(a) or 403(b), or an eligible governmental plan described in Code section 457(b), that accepts the eligible rollover distribution.

(3) If the Plan permits Roth Deferrals, the Plan may accept a rollover contribution to a Roth Deferral Account only if it is a direct rollover from another Roth deferral account under an applicable retirement plan described in Code section 402A(e)(1) and only to the extent the rollover is permitted under the rules of Code section 402(c).

(c) Separate Accounting. The Plan shall establish and maintain for the Participant a separate Account for any eligible rollover distribution paid to the Plan from any eligible retirement plan that is not an eligible governmental plan under

Code section 457(b). In addition, the Plan shall establish and maintain for the Participant a separate Account for any eligible rollover distribution paid to the Plan from any eligible retirement plan that is an eligible governmental plan under Code section 457(b).

Section 5.05 EARNINGS/EXPENSES

(a) Earnings. A Participant's Accounts shall be credited with earnings in the manner specified in the Adoption Agreement. The Plan Administrator shall credit investment experience to each Participant's Account as of each Valuation Date specified in the Adoption Agreement. Except as provided in Subsection (c), if the Adoption Agreement provides for predetermined investments, such investments are to be used for measurement purposes only and there is no obligation for the Plan Administrator or Company to set aside, fund or actually purchase any investments.

(b) Expenses. The expenses of administering the Plan, including (i) expenses incurred by the Plan Administrator in the administration of the Plan, (ii) fees and expenses approved by the Plan Administrator for investment advisory, custodial, recordkeeping, and other plan administration and communication services, and (iii) any other expenses or charges allocable to the Plan that have been approved by the Plan Administrator may be charged, at the discretion of the Plan Administrator, to Participants' Account balances. If amounts are deposited into an account or trust owned by the Employer, brokerage fees, transfer taxes, and any other costs incident to the purchase or sale of securities or other investments shall be deemed to be part of the cost of such securities or investments or deducted in computing the sales proceeds therefrom and shall be accounted for accordingly.

(c) Governmental Plan. If the Plan is a Governmental Plan, the earnings/losses shall be determined with respect to the Participant's allocable share of the earnings and losses of the Trust Fund.

Section 5.06 VESTING

(a) A Participant shall have a fully vested and nonforfeitable interest in his Accounts relating to Participant contributions.

(b) Subject to the provisions of Section 5.02(h), the Participant's interest in his Accounts relating to Company contributions shall vest based on his years of vesting service in accordance with the terms of the Adoption Agreement.

For purposes of the Adoption Agreement, "3-7 Year Graded", "2-6 Year Graded", "1-5 Year Graded", "1-4 Year Graded", "5 Year Cliff", "3 Year Cliff" and "2 Year Cliff" shall be determined in accordance with the following schedules:

	Years of Vesting Service	Vesting Percentage
"3-7 Year Graded":		
	Less than Three Years	0%
	Three Years but less than Four Years	20%
	Four Years but less than Five Years	40%
	Five Years but less than Six Years	60%
	Six Years but less than Seven Years	80%
	Seven or More Years	100%
"2-6 Year Graded":		
	Less than Two Years	0%
	Two Years but less than Three Years	20%
	Three Years but less than Four Years	40%
	Four Years but less than Five Years	60%
	Five Years but less than Six Years	80%
	Six or More Years	100%

"1-5 Year Graded":

Less than One Year	0%
One Year but less than Two Years	20%
Two Years but less than Three Years	40%
Three Years but less than Four Years	60%
Four Years but less than Five Years	80%
Five or More Years	100%

"1-4 Year Graded":

Less than One Year	0%
One Year but less than Two Years	25%
Two Year but less than Three Years	50%
Three Years but less than Four Years	75%
Four or More Years	100%

"5 Year Cliff":

Less than Five Years	0%
Five or More Years	100%

"3 Year Cliff":

Less than Three Years	0%
Three or More Years	100%

"2 Year Cliff":

Less than Two Years	0%
Two or More Years	100%

In addition, the Adoption Agreement may provide that a Participant will become fully (100%) vested upon: (i) his attainment of Normal Retirement Age while an Employee, (ii) his death while an Employee, (iii) his suffering a disability while an Employee, or (iv) other event as specified in the Adoption Agreement.

(c) Special Forfeitures. Notwithstanding any provision to the contrary, a Participant shall also forfeit his or her Account pursuant to any special forfeiture provisions in the Adoption Agreement. Such special forfeiture provisions may include, without limitation, a provision requiring complete forfeiture of Participant's Account upon the occurrence of a specified event.

Section 5.07 FORFEITURES

(a) Non Governmental Plan. If the Plan is not a Governmental Plan, all forfeitures shall revert to the Company.

(b) Governmental Plan. If the Plan is a Governmental Plan, forfeitures shall be used to reduce Company contributions or to pay Plan expenses.

ARTICLE 6 DISTRIBUTIONS

Section 6.01 TIME OF DISTRIBUTION

(a) Non Governmental Plan. If the Plan is not a Governmental Plan and except as provided in Sections 6.03 and 6.04, benefits shall commence no earlier than the sixty-first (61st) day following: (i) the date of the Participant's Termination or, (ii) if earlier and so provided in the Adoption Agreement, the date the Participant attains age 70-1/2. Not later than sixty (60) days following the date the Participant becomes eligible to commence distributions, the Participant may elect a commencement date for all of the Participant's Account balance. A Participant's election of a benefit commencement date under this Section shall be irrevocable, provided, however, the Participant may, at least 30 days prior to such commencement date, elect a deferred commencement date as permitted under Code section 457(e)(9)(B). Any Participant who has made such a second election of a deferred commencement date may not thereafter revoke or modify that election. Benefits may not commence later than the date specified in the Adoption Agreement.

(b) Governmental Plan. If the Plan is a Governmental Plan and except as provided in Sections 6.03, 6.04 and 6.07, upon (i) Termination or (ii) if earlier and so provided in the Adoption Agreement, the date the Participant attains age 70-1/2, a Participant shall be entitled to receive a distribution of his or her Account under any form of distribution permitted under Section 6.02 commencing at the date elected by the Participant. Benefits may not commence later than the date specified in the Adoption Agreement.

(c) Participants Receiving Differential Wage Payments During Service in the Uniformed Service. A Participant receiving differential wage payments (as defined in Code section 3401(h)(2)) shall be treated as having Terminated from employment during any period of services described in Code section 3401(h)(2)(A). If a Participant elects to receive a distribution by reason of this paragraph, the Participant may not make a Participant Contribution during the 6-month period beginning on the date of distribution.

(d) Ordering Rule. The Plan Administrator shall determine the ordering rule for distributions; provided that such ordering rule is nondiscriminatory. Such ordering rule may provide that the Participant or Beneficiary may elect to have payments made first or last from his Roth Deferral Account and any other Account.

Section 6.02 FORM OF DISTRIBUTION

(a) In General. A Participant's benefit under the Plan may only be paid in the forms and medium specified in the Adoption Agreement and permitted under Code section 457 and regulations promulgated thereunder. No election of a distribution form under this Section may be made or changed after the commencement date for such distribution form. If an election is not made prior to the date benefits commence under Section 6.01, distributions shall be made in a single lump sum payment as soon as practicable thereafter.

(b) Limitations. No distribution option may be selected by a Participant or Beneficiary under this Article 6 unless it satisfies the requirements of Code sections 401(a)(9) and 457(d).

(c) Cash Outs. The Plan Administrator reserves the right to adopt guidelines under which Account balances below a specified level may be distributed in a lump sum upon Termination or at a deferred commencement date and to establish minimum amounts of installment payments.

Section 6.03 SMALL DISTRIBUTIONS

To the extent provided in the Adoption Agreement, the Plan Administrator reserves the right, subject to the limitations of Code section 457(e)(9)(A), to establish uniform guidelines under which all or a portion of a Participant's Account balances may be distributed in a lump sum before the Participant's Termination, and either with or without the Participant's consent,

provided that (i) the amount of the distribution does not exceed $5,000 (or the dollar limit under Code section 411(a)(11), if greater), (ii) no Deferral has been credited to the Participant's Account in the preceding twenty-four (24) months, and (iii) no prior payment has been made to the Participant under this Section.

Section 6.04 UNFORESEEABLE EMERGENCIES

(a) In General. If the Participant has an unforeseeable emergency before retirement or other Termination, the Participant may elect to receive a lump sum distribution equal to the amount requested or, if less, the maximum amount determined by the Plan Administrator to be permitted to be distributed under this Section.

(b) Unforeseeable Emergency Defined. An unforeseeable emergency is defined as a severe financial hardship of the Participant resulting from:

(1) an illness or accident of the Participant, the Participant's spouse, the Participant's Beneficiary, or the Participant's dependent (as defined in Code section 152 determined without regard to Code section 152(b)(1), (b)(2) and (d)(1)(B));

(2) loss of the Participant's property due to casualty (including the need to rebuild a home following damage to a home not otherwise covered by homeowner's insurance, e.g., as a result of a natural disaster);

(3) the need to pay for the funeral expenses of the Participant's spouse, Beneficiary or dependent (as defined in Code section 152 determined without regard to Code section 152(b)(1), (b)(2) and (d)(1)(B));

(4) or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant.

For example, the imminent foreclosure of or eviction from the Participant's primary residence may constitute an unforeseeable emergency. In addition, the need to pay for medical expenses, including non-refundable deductibles, the cost of prescription drug medication, and other similar situations, such as those described in Revenue Ruling 2010-27 (significant water damage from a water leak and funeral expenses for an adult child who is not a dependent; credit card debt is not considered unforeseeable), may constitute an unforeseeable emergency. Except as otherwise specifically provided in this Section, neither the purchase of a home nor the payment of college tuition is an unforeseeable emergency.

(c) Unforeseeable Emergency Distribution Standard. A distribution on account of unforeseeable emergency may not be made to the extent that such emergency is or may be relieved through reimbursement or compensation from insurance or otherwise, by liquidation of the Participant's assets, to the extent the liquidation of such assets would not itself cause severe financial hardship, or by cessation of deferrals under the Plan.

(d) Distribution Necessary to Satisfy Emergency Need. Distributions because of an unforeseeable emergency may not exceed the amount reasonably necessary to satisfy the emergency need (which may include any amounts necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated to result from the distribution).

Section 6.05 DEATH

(a) In General. Payments to the Participant's Beneficiary shall be subject to the election procedures in Section 6.01 and shall be made in the time and form specified in the Adoption Agreement.

(b) Death Benefits Under USERRA. Effective January 1, 2007, if the Adoption Agreement specifies the Plan is a Governmental Plan, and a Participant dies while performing qualified military service (as defined in Code section 414(u)), the survivors of the Participant are entitled to any additional benefits (other than benefit accruals relating to the period of qualified military service) provided under the plan had the Participant resumed and then Terminated employment on account of death

pursuant to Code section 401(a)(37), Notice 2010-5 and any superseding guidance. For example, this may include full vesting for death while an Employee under Section 5.06(b) if provided under the Adoption Agreement.

Section 6.06 WITHHOLDING

To the extent required by applicable law, income and other taxes shall be withheld from each payment, and payments shall be made reported to the appropriate governmental agency or agencies.

Section 6.07 DISTRIBUTIONS FROM ROLLOVER ACCOUNT

If the Plan is a Governmental Plan and a Participant has a separate Account attributable to rollover contributions to the Plan, the Participant may at any time elect to receive a distribution of all or any portion of the amount held in the rollover Account to the extent provided in the Adoption Agreement.

Section 6.08 TRANSFERS

This Section shall apply to the extent that the Adoption Agreement permits transfers to another Eligible Deferred Compensation Plan. At the direction of the Company, the Plan Administrator may transfer assets to the other Plan as provided in this Section. Such a transfer is permitted only if the other plan provides for such direct transfer. The Plan Administrator may require such documentation from the other plan as it deems necessary to effectuate the transfer. A transfer shall only be permitted to the extent that it is permissible in accordance with Code section 457(e)(10) and Treas. Reg. section 1.457-10(b).

Section 6.09 DIRECT ROLLOVERS - GOVERNMENTAL PLANS

(a) In General. This Section shall only apply to a Governmental Plan. A Participant, the surviving spouse of a Participant (or a Participant's former spouse who is the alternate payee under a domestic relations order, as defined in Code section 414(p)), or a non-spouse beneficiary who is entitled to an eligible rollover distribution may elect, at the time and in the manner prescribed by the Plan Administrator, to have all or any portion of the distribution paid directly to an eligible retirement plan specified by the Participant in a direct rollover. A non-spouse beneficiary must be a designated beneficiary within the meaning of Code section 401(a)(9)(E) and such direct rollovers shall be subject to the terms and conditions of IRS Notice 2007-7 and superseding guidance, including but not limited to the provision in Q&A-17 regarding required minimum distributions.

(b) Eligible Rollover Distribution. For purposes of this Section, an eligible rollover distribution means any distribution of all or any portion of a Participant's Account, except that an eligible rollover distribution does not include (1) any installment payment for a period of 10 years or more (2) any distribution made as a result of an unforeseeable emergency, or (3) for any other distribution, the portion, if any, of the distribution that is a required minimum distribution under Code section 401(a)(9). In addition, an eligible retirement plan means an individual retirement account described in Code section 408(a), an individual retirement annuity described in Code section 408(b), a qualified trust described in Code section 401(a), an annuity plan described in Code section 403(a) or 403(b), an eligible governmental plan described in Code section 457(b), or a Roth IRA (subject to Code sections 408A(c)(3)(B) and 457(e)(16)) that accepts the eligible rollover distribution.

If any portion of an eligible rollover distribution is attributable to payments or distributions from a Roth Deferral Account, an eligible retirement plan shall only include another Roth deferral account under an applicable retirement plan described in Code section 402A(e)(1) or to a Roth IRA described in Code section 408A and only to the extent the rollover is permitted under the rules of Code section 402(c).

(c) Mandatory Rollover. In the event of a mandatory distribution greater than $1,000 in accordance with the provisions of Sections 6.02 and 6.03, if the Participant does not elect to have such distribution paid directly to an eligible retirement plan specified by the Participant in a direct rollover or to receive the distribution directly, then the Plan Administrator will pay the distribution in a direct rollover to an individual retirement plan designated by the Plan Administrator.

Section 6.10 SERVICE CREDIT TRANSFERS

(a) This Section shall only apply to a Governmental Plan. If permitted in the Adoption Agreement and a Participant is also a participant in a tax-qualified defined benefit governmental plan (as defined in Code section 414(d)) that provides for the acceptance of plan-to-plan transfers with respect to the Participant, then the Participant may elect to have any portion of the Participant's Account transferred to the defined benefit governmental plan. A transfer under this Section may be made before the Participant has Terminated.

(b) A transfer may be made under Section only if the transfer is either for the purchase of permissive service credit (as defined in Code section 415(n)(3)(A)) under the receiving defined benefit governmental plan or a repayment to which Code section 415 does not apply by reason of Code section 415(k)(3).

Section 6.11 QUALIFIED HEALTH INSURANCE PREMIUMS FOR RETIRED PUBLIC SAFETY OFFICERS

If the Adoption Agreement specifies that the Plan is a Governmental Plan, the Plan Administrator may allow retired public safety officers to elect to have distributions used to pay for qualified health insurance premiums as provided in Code section 402(l). Such distributions shall be subject to the terms and conditions of IRS Notice 2007-7 and superseding guidance.

Section 6.12 DEATH OR DISABILITY DURING QUALIFIED MILITARY SERVICE

If provided in the Adoption Agreement, a Participant that dies or becomes disabled while performing qualified military service (as defined in Code section 414(u)) will be treated as if he had been employed by the Company on the day preceding death or disability and Terminated employment on the day of death or disability and receive benefit accruals related to the period of qualified military service as provided under Code section 414(u)(8), subject to paragraphs (a) and (b) below:

(a) All Participants eligible for benefits under the Plan by reason of this section shall be provided benefits on reasonably equivalent terms.

(b) For the purposes of applying Code section 414(u)(8)(C), a Participant's contributions shall be determined based on the Participant's average actual contributions for:

(1) the 12-month period of service with the Employer immediately prior to qualified military service, or

(2) if service with the Employer is less than such 12-month period, the actual length of continuous service with the employer.

Section 6.13 LOANS

(a) In General. If the Plan is a Governmental Plan and if the Adoption Agreement so provides, a Participant who is an Employee may apply for and receive a loan from his or her Account as provided in this Section. Any such loan may not be for an amount less than the minimum amount specified by the Administrator. If not specified by the Plan Administrator, the minimum loan amount shall be $1,000.

(b) Maximum Loan Amount. No loan to a Participant hereunder may exceed the lesser of: (x) $50,000, reduced by the greater of (i) the outstanding balance on any loan from the Plan to the Participant on the date the loan is made or (ii) the highest outstanding balance on loans from the Plan to the Participant during the one-year period ending on the day before the date the loan is approved by the Plan Administrator (not taking into account any payments made during such one-year period), or (y) one half of the value of the Participant's vested Account (as of the Valuation Date immediately preceding the date on which such

loan is approved by the Plan Administrator). For purposes of this Subsection, any loan from any other plan maintained by a participating employer shall be treated as if it were a loan made from the Plan, and the Participant's vested interest under any such other plan shall be considered a vested interest under this Plan; provided, however, that the provisions of this Subsection shall not be applied so as to allow the amount of a loan under this Section to exceed the amount that would otherwise be permitted in the absence of this Subsection.

(c) Terms of Loan. The terms of the loan shall:

(1) require level amortization with payments not less frequently than quarterly throughout the repayment period, except that alternative arrangements for repayment may apply in the event that the borrower is on a bona fide unpaid leave of absence for a period not to exceed one year for leaves other than a qualified military leave within the meaning of Code section 414(u) or for the duration of a leave which is due to qualified military service;

(2) require that the loan be repaid within five years unless the Participant certifies in writing to the Plan Administrator that the loan is to be used to acquire any dwelling unit which within a reasonable time is to be used (determined at the time the loan is made) as a principal residence of the Participant; and

(3) provide for interest at a rate equal to one percentage point above the prime rate as published in the *Wall Street Journal* on the first business day of the month in which the loan is approved by the Plan Administrator.

(d) Security for Loan; Default.

(1) Security. Any loan to a Participant under the Plan shall be secured by the pledge of the portion of the Participant's interest in the Plan invested in such loan.

(2) Default. In the event that a Participant fails to make a loan payment under this Section within 90 days after the date such payment is due, a default on the loan shall occur. In the event of such default, (i) all remaining payments on the loan shall be immediately due and payable, (ii) effective as of the first day of the calendar month next following the month in which any such loan default occurs, the interest rate for such loan shall be (if higher than the rate otherwise applicable) the rate being charged on loans from the Plan that are approved by the Plan Administrator in the month in which such default occurs, (iii) no contributions shall be made on such Participant's behalf prior to the first payroll period that follows by 12 calendar months the date of repayment in full of such loan, and (iv) the Participant shall be permanently ineligible for any future loans from the Plan. In the case of any default on a loan to a Participant, the Plan Administrator shall apply the portion of the Participant's interest in the Plan held as security for the loan in satisfaction of the loan on the date of Termination. In addition, the Plan Administrator shall take any legal action it shall consider necessary or appropriate to enforce collection of the unpaid loan, with the costs of any legal proceeding or collection to be charged to the Account of the Participant.

(e) Death. Notwithstanding anything elsewhere in the Plan to the contrary, in the event a loan is outstanding hereunder on the date of a Participant's death, his or her estate shall be his or her Beneficiary as to the portion of his or her interest in the Plan invested in such loan (with the Beneficiary or Beneficiaries as to the remainder of his or her interest in the Plan to be determined in accordance with otherwise applicable provisions of the Plan).

(f) Repayment. The Participant may be required, as a condition to receiving a loan, to enter into an irrevocable agreement authorizing the Employer to make payroll deductions from his or her Compensation as long as the Participant is an Employee and to transfer such payroll deduction amounts to the Trustee in payment of such loan plus interest. Repayments of a loan shall be made by payroll deduction of equal amounts (comprised of both principal and interest) from each paycheck, with the first such deduction to be made as soon as practicable after the loan funds are disbursed; provided however, that a Participant may prepay the entire outstanding balance of his loan at any time (but may not make a partial prepayment); and provided, further, that if any payroll deductions cannot be made in full because a Participant is on an unpaid leave of absence or is no longer employed by a participating employer (that has consented to make payroll deductions for this purpose) or the Participant's paycheck is insufficient for any other reason, the Participant shall pay directly to the Plan the full amount that would have been deducted from the Participant's paycheck, with such payment to be made by the last business day of the calendar month in which the amount would have been deducted.

Section 6.14 REFUNDS/INDEMNIFICATION

If the Plan Administrator determines that any person has directly or indirectly received excess payments under the Plan, the Plan Administrator shall notify such person and such person shall repay such excess amount as soon as possible, but in no event later than 30 days after the date of notification. A person receiving excess payments shall indemnify and reimburse the Company for any liability the Company may incur for making such payments. If a person fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset the person's salary or wages, and/or (ii) offset other benefits payable hereunder.

Section 6.15 CLAIMS PROCEDURE

(a) If the Adoption Agreement specifies that the Plan is a Governmental Plan, claims procedures shall be established by the policies and procedures of the Plan Administrator and/or Company and any other applicable law.

(b) If the Adoption Agreement specifies that the Plan maintained by a tax-exempt entity, claims procedures shall be established by the policies and procedures of the Plan Administrator and/or Company in conformance with ERISA section 503 and comply with the provisions below.

(1) Application for Benefits. A Participant or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim shall be in writing and shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

(2) Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days (45 days if the claim relates to a disability determination) after receipt of the claim. This period may be extended one time by the Plan for up to 90 days (30 additional days if the claim relates to a disability determination), provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial review period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the claim relates to a disability determination, the period for making the determination may be extended for up to an additional 30 days if the Plan Administrator notifies the Claimant prior to the expiration of the first 30-day extension period.

(3) Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

(4) Appeals of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day (180th day if the claim relates to a disability determination) after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall ordinarily rule on an appeal within 60 days (45 days if the claim relates to a disability determination). However, if special circumstances require an extension and the Plan Administrator furnishes the Claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days (90 days if the claim relates to a disability determination) to rule on an appeal.

(5) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.

(6) Determinations of Disability. If the claim relates to a disability determination, determinations of the Plan Administrator shall include the information required under applicable United States Department of Labor regulations.

Section 6.16 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment shall fully discharge the Plan Administrator and the Company from further liability on account thereof.

Section 6.17 MISSING PAYEE

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

Section 6.18 2009 REQUIRED MINIMUM DISTRIBUTIONS

Notwithstanding other provisions of the Plan to the contrary; to the extent provided by the Adoption Agreement and by Code section 401(a)(9), IRS Notice 2009-82 and any superseding guidance, a participant or beneficiary who would have been required to receive 2009 RMDs or Extended 2009 RMDs will receive those distributions for 2009 unless the participant or beneficiary chooses not to receive such distributions. Participants and beneficiaries described in the preceding sentence will be given the opportunity to elect to stop receiving the distributions described in the preceding sentence.

(a) In addition, notwithstanding other provisions of the Plan to the contrary, and solely for purposes of applying the direct rollover provisions of the Plan, certain additional distributions in 2009, as chosen above, will be treated as eligible rollover distributions.

(b) Definitions:

(1) "2009 RMDs" are required minimum distributions for 2009 but for the enactment of section 401(a)(9)(H) of the Code;

(2) "Extended 2009 RMDs" are one or more payments in a series of substantially equal distributions (that include the 2009 RMDs) made at least annually and expected to last for the life (or life expectancy) of the participant, the joint lives (or joint life expectancy) of the participant and the participant's designated beneficiary, or for a period of at least 10 years.

ARTICLE 7 PLAN ADMINISTRATION

Section 7.01 PLAN ADMINISTRATOR

(a) Designation. The Plan Administrator shall be specified in the Adoption Agreement. In the absence of a designation in the Adoption Agreement, the Plan Sponsor shall be the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be Employees appointed by the Plan Sponsor and the Committee shall elect a chairman and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents in its behalf.

(b) Authority and Responsibility of the Plan Administrator. The Plan Administrator shall be the Plan "administrator" as such term is defined in section 3(16) of ERISA, and as such shall have total and complete discretionary power and authority:

(i) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(ii) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 6;

(iii) to determine the amount and manner of any allocations and/or benefit accruals hereunder;

(iv) to maintain and preserve records relating to Participants, former Participants, and their Beneficiaries and alternate payees;

(v) to prepare and furnish to Participants, Beneficiaries and alternate payees all information and notices required under applicable law or the provisions of this Plan;

(vi) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(vii) to approve and enforce any loan hereunder including the repayment thereof;

(viii) to provide directions to the trustee of a trust established in conjunction with this Plan (if any) with respect to timing and methods of benefit payment, valuations at dates other than regular valuation dates and on all other matters where called for in the Plan or requested by the trustee;

(ix) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(x) to determine all questions of the eligibility of Employees and of the status of rights of Participants, Beneficiaries and alternate payees;

(xi) to adjust Accounts in order to correct errors or omissions;

(xii) to determine the status and effect of any domestic relations order and to take such action as the Plan Administrator deems appropriate in light of such domestic relations order;

(xiii) to retain records on elections and waivers by Participants, their spouses and their Beneficiaries and alternate payees;

(c) Procedures. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan, including but not limited to, procedures relating to requirements for advance notice of any election or modification of an election, minimum and maximum amount of contributions, the types of compensation that may be deferred, the minimum amounts or percentages that may be allocated among investment options, and the timing and frequency of changes to investment elections. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) Allocation of Duties and Responsibilities. The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) Compensation. The Plan Administrator shall serve without compensation for its services.

(f) Expenses. All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Company.

(g) Allocation of Fiduciary Duties. A Plan fiduciary shall have only those specific powers, duties, responsibilities and obligations as are explicitly given him under the Plan. It is intended that each fiduciary shall not be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

Section 7.02 FUNDED STATUS

(a) Unfunded Plan. This Subsection applies if the Plan is not a Governmental Plan. The Plan is intended to constitute an unfunded plan. Any amount due and payable pursuant to the terms of the Plan shall be paid out of the general assets of the Company except to the extent that it is paid from a grantor trust. All assets of the Plan shall be subject to the claims of creditors of the Company. Participants and Beneficiaries shall not have an interest in any specific asset of the Company or in any specific asset held in a grantor trust or a Company account established as a result of participation in this Plan. Except as may be provided under the terms of a grantor trust, the Company shall have no obligation to set aside any funds for the purpose of making any benefit payments under this Plan. Nothing contained herein shall give any Participant any rights that are greater than those of an unsecured creditor of the Company with respect to any unpaid amount as to which the Participant has a vested interest. No action taken pursuant to the terms of this Plan shall be construed to create a funded arrangement, a plan asset, or fiduciary relationship among the Company, its designee and a Participant or Beneficiary.

(b) Trust Fund. This Subsection applies if the Plan is a Governmental Plan.

(1) Assets Held in Trust. All contributions, all property and rights purchased with such amounts, and all income attributable to such amounts, property, or rights shall be held and invested in the Trust Fund in accordance with this Plan and the Trust Agreement. The Trust Fund, and any subtrust established under the Plan, shall be established pursuant to a written agreement. The Trustee shall ensure that all investments, amounts, property, and rights held under the Trust Fund are held for the exclusive benefit of Participants and their Beneficiaries. The Trust Fund shall be held in trust pursuant to the Trust Agreement for the exclusive benefit of Participants and their Beneficiaries and defraying reasonable expenses of the Plan and of the Trust Fund. It shall be impossible, prior to the satisfaction of all liabilities with respect to Participants and their Beneficiaries, for any part of the assets and income of the Trust Fund to be used for, or diverted to, purposes other than for the exclusive benefit of Participants and their Beneficiaries.

(2) Custodial Accounts and Annuity Contracts. For purposes of the trust requirement of this Subsection (b), custodial accounts and annuity contracts described in Code section 401(f) that satisfy the requirements of Treas. Reg. 1.457-8(a)(3) are treated as trusts under rules similar to the rules of Code section 401(f).

(3) Creditors. Except as expressly provided in the Plan, the interests of each Participant or Beneficiary under the Plan are not subject to the claims of the Participant's or Beneficiary's creditors.

(4) IRS Levy. the Plan Administrator may pay from a Participant's or Beneficiary's Account balance the amount that the Plan Administrator finds is lawfully demanded under a levy issued by the Internal Revenue Service with respect to that Participant or Beneficiary or is sought to be collected by the United States Government under a judgment resulting from an unpaid tax assessment against the Participant or Beneficiary.

(5) Mistaken Contributions. If any contribution (or any portion of a contribution) is made to the Plan by a good faith mistake of fact, then within one year after the payment of the contribution, and upon receipt in good order of a proper request approved by the Plan Administrator, the amount of the mistaken contribution (adjusted for any income or loss in value, if any, allocable thereto) shall be returned directly to the Participant or, to the extent required or permitted by the Plan Administrator, to the Employer.

Section 7.03 INDEMNIFICATION

Unless otherwise provided in the Adoption Agreement, the Company shall indemnify and hold harmless any person serving as the Plan Administrator and, if applicable, the Trustee (and their delegates) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan.

Section 7.04 COMMUNICATIONS

All enrollments, elections, designations, applications and other communications by or from an employee, Participant, Beneficiary, or legal representative of any such person regarding that person's rights under the Plan shall be made in the form and manner established by the Plan Administrator. Neither the Plan Administrator nor the Company shall be required to give effect to any such communication that is not made on the prescribed form and in the prescribed manner and that does not contain all information called for on the prescribed form.

ARTICLE 8 AMENDMENT AND TERMINATION

Section 8.01 AMENDMENT/TERMINATION

The provisions of the Plan may be amended and or terminated in writing at any time and from time to time by the Plan Sponsor. Notwithstanding the foregoing, an amendment/termination shall have no effect to the extent that it impermissibly accelerates a benefit payment or otherwise does not comply with Code section 457 and the regulations promulgated thereunder. Distributions may be made upon termination of the Plan to the extent such payments comply with Treas. Reg. section 1.457-10(a). No amendment or termination specified in this Article 8 shall result in a reduction or forfeiture of a Participant's Account unless such reduction or forfeiture is expressly provided under the terms of the Plan.

ARTICLE 9 MISCELLANEOUS

Section 9.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he may expect to receive, contingently or otherwise, under the Plan.

Section 9.02 QDRO

Notwithstanding Section 9.01, if a judgment, decree or order (including approval of a property settlement agreement) that relates to the provision of child support, alimony payments, or the marital property rights of a spouse or former spouse, child, or other dependent of a Participant is made pursuant to the domestic relations law of any state ("domestic relations order"), then the amount of the Participant's Account shall be paid in the manner and to the person or persons so directed in the domestic relations order. Such payment shall be made without regard to whether the Participant is eligible for a distribution of benefits under the Plan. The Plan Administrator shall establish reasonable procedures for determining the status of any such decree or order and for effectuating distribution pursuant to the domestic relations order.

Section 9.03 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Company and the Participant, or as a right of any Employee to continue in the employment of the Company, or as a limitation of the right of the Company to discharge any of its Employees, with or without cause.

Section 9.04 GOVERNING LAW

The Plan shall be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by Federal law.

Section 9.05 TAX EFFECT

The Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation. Furthermore, the Company does not represent or guarantee investment returns with respect to any predetermined investment options and shall not be required to restore any loss which may result from such investment or lack of investment.

Section 9.06 ASSIGNMENT

The Company may transfer, assign or encumber any of its rights, privileges, duties or obligations under this Agreement.

Section 9.07 SEVERABILITY OF PROVISIONS

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provisions had not been included.

Section 9.08 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 9.09 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

2025 Quality Improvement Health Equity Committee (QIHEC) Charter

Meeting Purpose

The purpose of the Quality Improvement Health Equity Committee (QIHEC) is to oversee and guide the development, implementation, and evaluation of the Community Health Plan of Imperial Valley's (CHPIV) Quality Improvement and Health Equity Transformation Program (QIHETP), ensuring performance improvement, health equity, and regulatory compliance across the provider network. This includes reviewing performance data, identifying and addressing deficiencies, fostering stakeholder engagement, and ensuring alignment with state and federal requirements.

Objectives

Review, analyze, evaluate, and act on the results of the Quality Improvement (QI), Health Equity (HE) and Population Health Management (PHM) activities to ensure CHPIV addresses members' needs and appropriately follows-up on performance deficiencies and gaps in care.

Responsibilities

The QIHEC Committee shall have the authority and responsibilities described below.

1. CHPIV Health Care Services team and Commission Clerk will facilitate meetings.
2. CHPIV Health Care Services team will take the lead on taking meeting minutes and action items and distributing to attendees after each meeting.
3. Health Net will ensure timely submissions of Monthly KPIs, Quarterly Logs and Standing Reports.
4. Semi-annually assess QI and HE activities and annually assess PHM and Utilization Management (UM) activities, including areas or success and needed improvements in services rendered within the QI and Health Equity program at the delegated, regional and/or county level.
    a. Conduct a quality review of all services rendered, the results of required performance measure reporting, and the results of efforts to reduce health disparities.
    b. Address activities and priorities related to the Quality Improvement and Health Equity Transformation Program (QIHETP).
    c. Analyze and evaluate the results of the QI and Health Equity activities including annual review of the results in performance measures, utilization data, and consumer satisfaction surveys.

5. Support efforts to align resources, strategies, and partners by place in order to reduce identified inequities (e.g., via use of Health Equity Improvement Zones).
6. Identify differences in quality of care and utilization of physical and behavioral health care services for members directly managed and delegated to providers.
7. Ensure that all interventions to address differences in quality of care and utilization have an equity of focus, including addressing underlying factors such as SDoH.
8. Review performance measure results and address deficiencies, including results and deficiencies of all fully delegates subcontractors and where CHPIV is the fully delegated subcontractor.
9. Ensure connectedness to the findings, recommendations and actions from the Provider Advisory Committee, Community Advisory Committee (CAC), and the Delegation Oversight Monitoring Meeting to streamline understanding and decision-making.
10. Ensure member confidentiality is maintained in QI discussions and ensures avoidance of conflict of interest among QIHEC members.
11. Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other CHPIV committees such as the Community Advisory Committee (CAC).
12. Institute actions to address performance deficiencies, including policy recommendations.
13. Ensure appropriate follow-up of identified performance deficiencies.
14. The QIHEC shall provide input and advice on the following non-exclusive list of topics:
    a. Population Health Management
    b. Health Delivery Systems Reforms to improve health outcomes
    c. Coordination of Care
    d. Clinical quality of physical and behavioral health care
    e. Access to primary and specialty health care providers and services
    f. Member experience in regard to clinical quality, access and availability, cultural and linguistics, competent health care and services, and continuity and coordination of care.
15. The QIHEC reviews reports submitted to QIHE chartered sub-committees including:
    a. DSNP Credentialing and Peer Review Subcommittee.
16. A written summary of QIHEC activities, as well as QIHEC activities of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, findings, recommendations, and actions, is prepared after each meeting of the QIHEC.
    1. CHPIV makes the written summary of QIHEC activities publicly available on CHPIV's website at least quarterly.
    2. Upon request, CHPIV submits written summaries of QIHEC proceedings to DHCS.
17. CHPIV ensures that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain a QIHEC that meets the requirements set forth above.
18. CHPIV ensures its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors report to CHPIV's QIHEC quarterly, at a minimum.
19. Review and reassess the adequacy of this Charter annually and recommend any proposed

changes to the Board for approval. The Committee shall annual review its own performance along with adequacy of member and reporting schedule. Changes can be mase as needed to ensure Committee efficacy.

The Board shall:

- Receive written QIHEC reports and meeting minutes from that previous QIHEC meeting.
- Approve the annual Health Equity Transformation Program (QIHETP) plan, QIHEC annual schedules, QI and HE program descriptions, QI and HE program workplans annually.
- Appoint an accountable entity or entities responsible for the oversight of the QIHETP.
- Direct necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity standards

Reporting Structure

1. QIHEC shall make formal recommendations to the Board of Directors to advance the QIHEC priorities and needed interventions.
3. The QIHEC Chair will ensure meeting minutes
1. Are approved quarterly by the QIHEC Voting Members
2. Are forwarded to the Compliance department on a quarterly basis for submission to regulatory bodies as needed.

Report Submissions

The delegate is responsible for submitting the following reports and in the event that the due date falls on a weekend or holiday, reports must be submitted on the preceding business day:

1. QI Workplan Evaluation
2. QI Annual Program Description
3. QI Workplan/Mid-Year Update
4. HEDIS Update
5. Initial Health Assessment Reports
6. Lead Screening Reports
7. Medical & Behavioral Health Care
8. Continuity & Coordination of Medical Care
9. Member Experience Report
10. CAHPS Workgroup Update
11. FSR & Accessibility Review

12. Community Advisory Committee Report
13. UM Program Description
14. Key Indicator Concurrent Review
15. Key Indicator Prior Authorization Report
    - CCS
    - TAT
16. File Audits
17. Inter Rater Reliability Results
18. Pharmacy & Therapeutics Subcommittee Minutes
19. Service Coordination Reports
20. UM/CM Workplan
21. UM/CM Mid-Year Update
22. Over/Under-Utilization Report
23. CM Program Description
24. CM Program Evaluation
25. CM Key Indicator Report
    - Workplan Review
    - File Audits
    - Member Satisfaction
26. Health Equity Workplan Evaluation
27. Health Equity Program Description
28. Health Equity Workplan/Mid-Year Update
29. Language Assistance Program Report
30. Access Report
31. Health Equity Governance Report
32. ECM/CS Performance Report
33. NSMHS Member and PCP Outreach & Education Plan
34. PNM Integrated Availability Report
35. DMHC Evaluation of Accessibility Report
36. Annual Integrated Accessibility Report
37. Network Access and Availability Governance Committee Update
38. Accessibility of Services Report
39. Assessment of Member Experience Accessing Network Report
40. Directory Accuracy Report
41. PHM Strategy Description
42. PHM Quarterly Update
43. PHM Assessment Report
44. Segmentation Report
45. Effectiveness Analysis Report
46. PHM VBP Worksheet
47. Quality & Accuracy of Member Benefit Information Report

48. Email Response Analysis Report
49. New Member Understanding Report
50. Member Service and Provider Call Center Report
51. Appeals & Grievances Report
52. Appeals & Grievances TAT and Volume Report
53. California Children's Service Report (CCS)
54. Medi-Cal LTSS Report
55. Behavioral Health Update
56. Peer Review Credentialing PQI/QOC Access Report
57. Credentialing Report
58. Delegation Oversight Committee Summary
59. Vendor Monitoring and Oversight Summary (including audit results)
60. Provider Satisfaction Survey Results
61. Provider Operations Manual Updates
    - BH (annual)
    - ECM/CS (semi-annual
62. Clinical Policies

Attendees:

The following individuals and departments are regular attendees of the QIHEC. Additional stakeholders may be invited to attend QIHEC meetings as needed.

1. **CHPIV**
   A. Chief Medical Officer (CMO) / Chief Health Equity Officer (CHEO)
   B. Executive Director, Health Services
   C. Care Management Manager
   D. Clinical Auditing Supervisor
   E. Project Supervisor
   F. Project Specialist
   G. Commission Clerk

2. **Voting Committee Members**

A. CHPIV ensures a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Subcontractors, Downstream Subcontractors, Network Providers, and members, actively participate in the QIHEC or in any sub-committee that reports to the QIHEC.

B. Participating Subcontractors, Downstream Subcontractors, and Network Providers must be representative of the composition of CHPIV's Provider Network and include, at a minimum, Network Providers who provide health care services to:
C. Members affected by Health Disparities;
D. Limited English Proficiency (LEP) members;
E. Children with Special Health Care Needs (CSHCN);
F. Seniors and Persons with Disabilities (SPDs); and
G. Persons with chronic conditions.
H. CHPIV's QIHEC includes representatives from the fully delegated entity.

Meeting Frequency & Structure

The QIHEC will convene quarterly on the 3rd Wednesday of each month from 12:00pm to 1:30pm. Meetings are subject to:

1. Rescheduling due to holidays or conflicting priority issues/activities.
2. Time adjustments to ensure availability of all required attendees.
3. Open Discussions - CHPIV & Health Net

Approval	
First Issued	05/01/2025
Approved	05/01/2025
Revised	

Health Services Report

1. Q1 QIHEC Presentation Materials
2. NCQA Accreditation Update

Operations Report

Date: June 4, 2025

From: Julia Hutchins, Chief Operating Officer

Executive Summary

This report contains a high-level summary of activities and priorities in the areas overseen by the Chief Operating Officer: product development, provider network, member experience and marketing and communications.

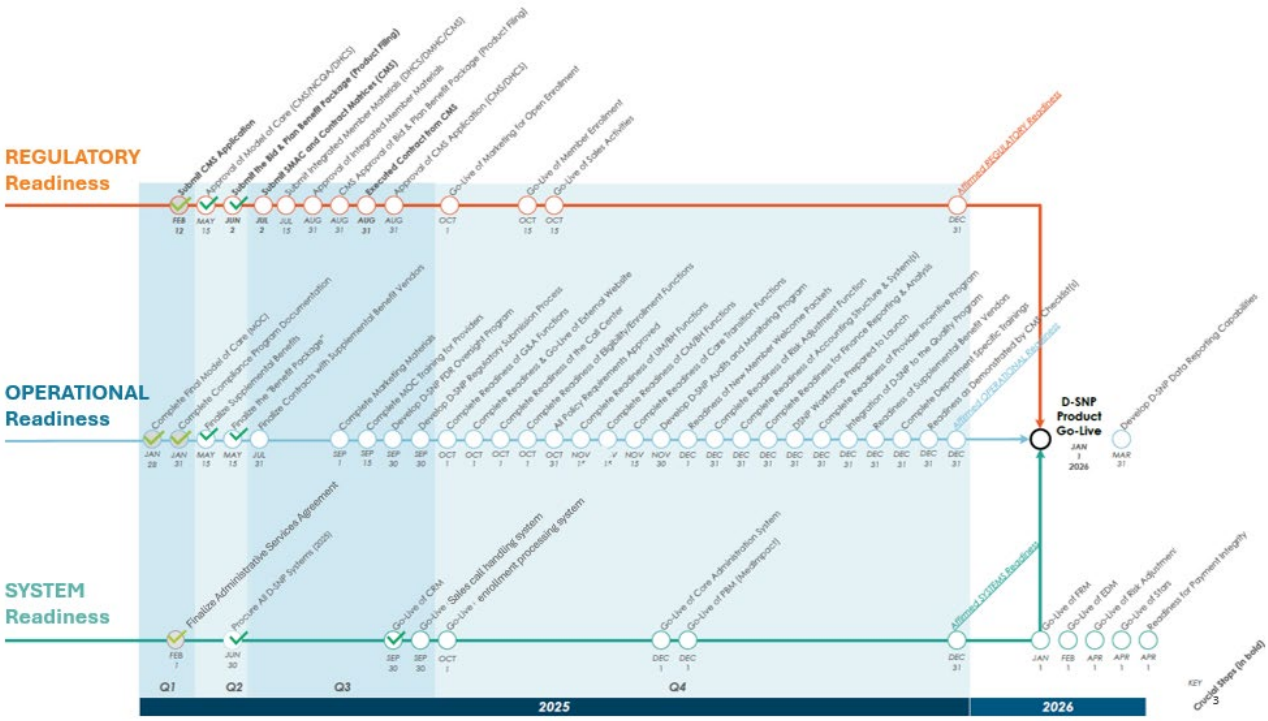
Product Development

Priority: Go-Live January 1, 2026 with D-SNP Offering, Community Advantage Plus

Activities:

- **Formulary:** Our D-SNP formulary has been successfully uploaded to CMS. It was prepared and reviewed by our administrative partner Community Health Group (CHG) and their PBM, MedImpact. We also submitted a medication therapy management plan, which will be administered by Outcomes, a downstream vendor of Community Health Group.
- **Bid:** The bid has been prepared by our actuarial consultants, Wakely, in conjunction with the CFO and COO. It is in final review and expected to be submitted by June 4. The bid is a critical component of CHPIV's Community Advantage Plus (HMO D-SNP) product. It establishes the scope of services and expected costs and revenues in 2026. The bid also allows us to align our offerings with the needs of dual-eligible beneficiaries, ensuring that our proposed benefits are both competitive and tailored to serve the population in Imperial County. Daniel O'Campo, Chief of Staff, has issued an RFP to supplemental benefit vendors.
- **Implementation:** On May 14, CHPIV clinical, finance, operations and compliance staff traveled to San Diego to meet with Community Health Group. We reviewed and finalized a joint work plan, and walked through a series of questions to help inform our pre-delegation review and operational understanding.

Metrics: Below is a high-level status report of critical implementation milestones.



Provider Network

Priorities: (1) Contract D-SNP network and (2) validate accuracy of Medi-Cal provider directory

Activities:

- **D-SNP Direct Network:** Daniel O'Campo, Chief of Staff, has implemented a contract management system through Panda Doc, which allows us to send agreements electronically, track changes, and manage contract execution and amendments. He is actively reaching out to and contracting with physician offices and ancillary providers in Imperial County to develop our directly contracted D-SNP network. We are working with a contract negotiator to assist with out-of-area hospital contracting, including UCSD.
- **IPA Networks:** We are conducting discovery sessions with contracted IPAs and CHG to make a final decision regarding delegation of inpatient UM. We have sent out implementation workplans to the IPAs and will be kicking off a regular implementation cadence and pre-delegation review this month.
- **Medi-Cal Non-Specialty Mental Health Network:** We plan to publish a CHPIV behavioral health resource directory for use by members and PCPs. As part of this project, we are reviewing Health Net's behavioral health network in Imperial County for accuracy and to identify those PCPs and therapists who are actively evaluating

and treating CHPIV Medi-Cal members. We will report the results of our findings to Health Net later this month. Last week, our team formally recognized the following providers for their work supporting the behavioral health care needs of our Medi-Cal members:

- Adriana Velasquez, LMFT
- Gabriel Lam, LCSW
- Jay Buenaflor, MD
- Vincent Soun, MD
- Vishwa Kapoor, MD

Metrics: Below is a summary of our direct network contracting activity.

	Sent Agreement	Executed LOA	In Credentialing	Executed Contract
Primary Care	8	3		
Specialist	23	6		
Behavioral Health	30	3	27	
Ancillary	TBD	11	n/a	2
Hospital	4	2		

Member Experience

Priorities: (1) Ensure compliant handling and tracking of online and in person member inquiries, and (2) increase Medi-Cal mental health visits for depression and anxiety by 10% (CAC goal).

Staffing: Ariday Rosales Rios, Member Coordinator, will be out on maternity leave through July. We have posted a receptionist position to ensure adequate front desk coverage. That position will report to Daniel. Michelle Ramirez has recently joined the CHPIV team as the Manager of Sales and Retention for Community Advantage Plus.

Activities:

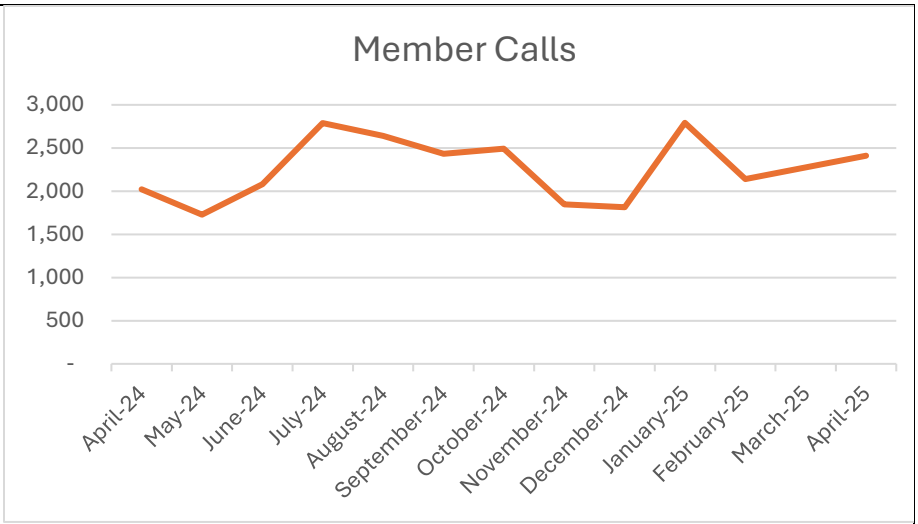
- **Community Advisory Committee**: We recently completed an internal evaluation of the committee to assess how well it is meeting our goals of compliance, impact and community reputation. We are making some changes to improve performance, including formally separating the CAC Selection Committee from the Community Advisory Committee:
    - The CAC Selection Committee is a committee of the Commission chaired by Dr. Ramirez. The purpose of the selection committee is to identify, recruit

and appoint members to the CAC. This committee will meet on **June 17** to review CHPIV's annual demographic report and CAC member composition. The selection committee is comprised of community leaders who have connections to underserved populations to ensure adequate representation on the CAC.

  - The CAC is a subcommittee of the QIHEC and is primarily comprised of CHPIV members appointed by the CAC selection committee. The purpose of the CAC is to engage members in discussions on ways to impact and shape CHPIV decision-making about health equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives and policies. The CAC will meet on **June 26**. The CHPIV CAC Coordinator will organize and chair the meeting.

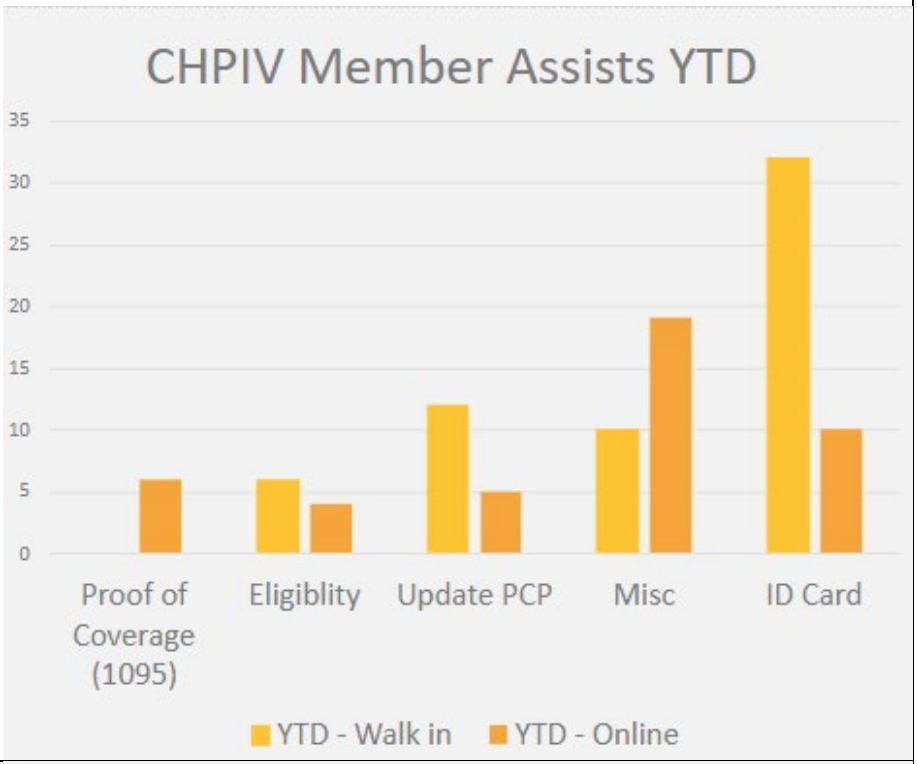
- **CAC Goal:** The CAC will provide feedback on proposed CHPIV interventions to increase mental health visits for depression and anxiety:
  - Teledoc
  - Mental health provider & resource directory
  - Member materials & social media campaign designed to reduce stigma
- **Contact Management System:** We are implementing a new HIPAA-compliant contact management system, Zendesk. We are currently using the system to manage and track member and provider inquiries handled by CHPIV staff. This system will also be used to track and record sales interactions with prospective members.

Metrics:

Health Net Member Inquires Top 5 call reasons (Apr): • Update PCP • Benefits & eligibility • Material Request • Auth inquiry • Coord of Benefits	

CHPIV Member Inquiries

Analysis: Volume remains low, and current staffing is adequate .



Net Promoter Score

Analysis: Gathering baseline data to inform future member services initiatives.

Goal: 20/mo
Result: Not met

Promoters (9-10)	Neutral (7-8)	Detractors (0-6)	NPS Score
20	4	3	77.27
91%	18%	14%	

The Net Promoter Score (NPS) serves as a benchmarking instrument for assessing member satisfaction. Our Member Experience team focused on calling members to inquire about their overall experience with CHPIV. The health insurance Industry has an average NPS of 27%.

Marketing & Communications

Priorities: (1) D-SNP marketing materials, (2) Mental health awareness

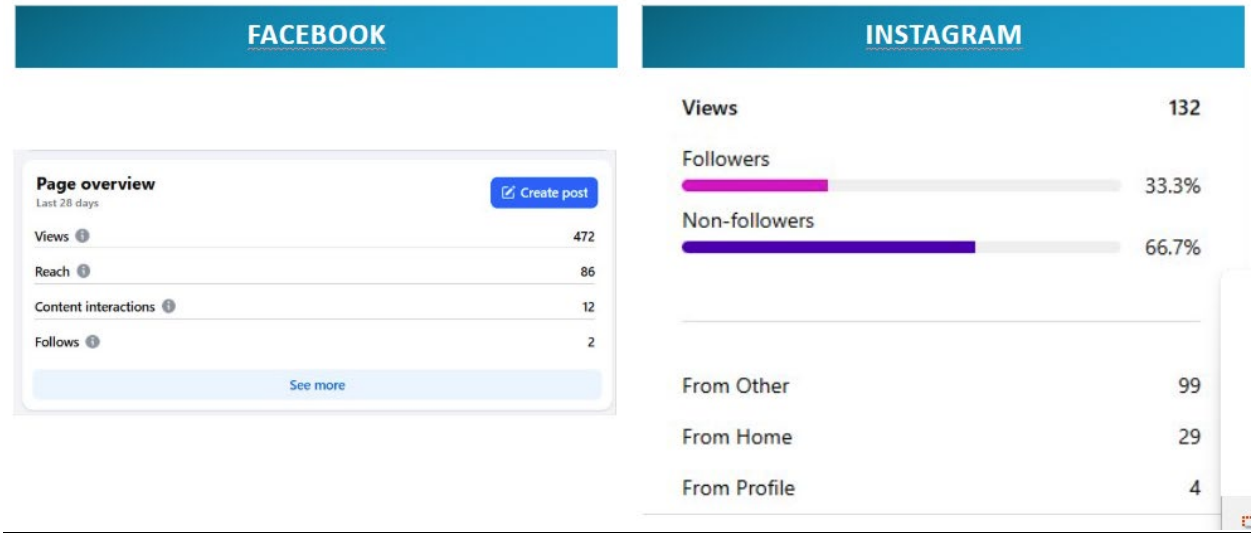
Staffing: Michelle Ortiz-Trujillo is no longer with CHPIV. We are in the process of restructuring the Department to maximize local community outreach and engagement.

Activities:

- **Community Stakeholder Meeting:** We are hosting a D-SNP community stakeholder meeting **on Jun 25** at the CHPIV offices to educate community members about why we are offering a D-SNP. DHCS will be attending the meeting virtually.
- **Behavioral Health Awareness:** We are launching a mental health awareness campaign to help support our CAC goal:

  Campaign: Your Mind Matters with CHPIV
  Duration: 8–10 Weeks
  Platforms: Facebook, Instagram | Language: Bilingual (EN/ES)
  Objectives:
  - Increase awareness and early use of preventive mental health care services.
  - Reduce stigma and clarify access points (PCP, Teladoc, local partners).
  - Empower members with tools to self-advocate and navigate care.

Metrics:



HUMAN RESOURCES REVIEW
June 9, 2025

THE MONTH IN REVIEW

- Continued work on performance evaluations
    - 90 day goal setting is now implemented for all new hires
    - Will finalize Rippling performance management module later this week
- 4 new hires, Compliance Manager, Compliance Coordinator (local), Sales Manager (local), Care Manager (Remote)
- 9 current open positions: Care Manager, Care Coordinator (6), Clinical Project Specialist, Front Desk Receptionist
- Employee handbook is back from legal review with 2 material changes. These will be presented to the Commission in July.

HR NUMBERS AT A GLANCE (THROUGH JUNE 9, 2025)

Total number of employees	25
Local	16
Remote	9
Number of exits in 2025	2