Pathways Home Health and Hospice

Pathways Home Health and Hospice Group Welfare Plan

Master Summary Plan Description

Amended Effective July 1, 2025

This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice reproduced in Appendix B for more details.

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1. Definitions

Capitalized terms used in this document have the following meanings:

"AD&D" means accidental death and dismemberment insurance.

“Affordable Care Act” means the Patient Protection and Affordable Care Act, as amended.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

"Company" means Pathways Home Health and Hospice or any successor thereto, and any affiliated entity within the same controlled group, as that term is defined under section 414(b) of the Internal Revenue Code, that participates in the plan.

"DCAP" means a dependent care assistance program that may be established by the Company under a separate document. The DCAP is a benefit program under the Plan. It may allow you to use pre-tax dollars to pay for the care of your eligible dependents while you are at work. It is not subject to ERISA.

"Employee" means any common-law employee of the Company who satisfies the eligibility provisions of in this document and is not excluded from participation by the terms of an applicable benefit program, except individuals classified or treated by the Company as independent contractors (regardless of any subsequent reclassification), or as an employee of an employment agency.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Health FSA" means a health flexible spending account plan that may be established by the Company under a separate document. The health FSA is a benefit program under the Plan. It allows you to use before-tax dollars to pay for most medical and dental expenses not reimbursed under other programs.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"Plan" means the Pathways Home Health and Hospice Group Welfare Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 15.

"Plan Administrator" means the Company.

"SPD" means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document, information booklets supplied by insurance carriers, and other benefits descriptions provided to participants with this document or at any other period as appropriate to provide updates to the document, such as during open enrollment.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended.

2. Introduction

The Company maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or “dependents.” It is important that you share this document and the materials referenced here in with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 15. See Section 15 for a listing of benefit programs and the entities that help administer the programs.

Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a "Benefit Description"). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self-funded is noted in Section 15.

This document and its attachments constitute the plan document required by ERISA § 402. This document and its attachments, coupled with the information booklets and other descriptive materials provided for benefits as described in Section 15 constitutes the wrap Summary Plan Description as required by ERISA § 102.

3. General Information about the Plan

Plan Name:	Pathways Home Health and Hospice Group Welfare Plan.
Type of Plan:	Welfare plan providing coverages listed in Section 15. The Plan also includes funding through a cafeteria plan under Code § 125.
Plan Year:	July 1 to June 30.
Plan Number:	501
Effective Date:	June 1, 1992. The Plan has been amended several times since its original effective date, most recently as of July 1, 2025.
Funding Medium and Type of Plan Administration:	All benefits under the Plan are fully-insured. See Section 15 for a description of the benefit programs that are fully-insured. For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO. The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below. Premiums for Employees and their eligible family members may be paid in part by the Company out of its general assets and in part by Employees' pre-tax and/or post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums

	during the initial and subsequent open enrollment periods and on request for each of the benefit programs, as applicable. The Company provides Employees the opportunity to pay for benefits on a pre-tax basis through a cafeteria plan. Appendix C provides information with regard to such a plan.
Plan Sponsor:	The Company is the Plan Sponsor. Pathways Home Health and Hospice 585 N. Mary Avenue Sunnyvale, CA 94085 (408) 730-5900
Plan Sponsor's Employer Identification Number:	94-2823240
Insurance Companies/HMO:	See a complete list under the heading Plan Provider Information later in this document.
Plan Administrator:	Attention: Director of Human Resources Pathways Home Health and Hospice 585 N. Mary Avenue Sunnyvale, CA 94085 (408) 730-5900
Named Fiduciary:	Pathways Home Health and Hospice 585 N. Mary Avenue Sunnyvale, CA 94085 (408) 730-5900
Agent for Service of Legal Process:	Pathways Home Health and Hospice 585 N. Mary Avenue Sunnyvale, CA 94085 (408) 730-5900 Service for legal process may also be made on the Plan Administrator.

Language assistance is available. If you have difficulty understanding any part of this Summary Plan Description, contact Human Resources.

Benefits hereunder may be provided pursuant to an insurance contract or pursuant to a governing document adopted by the Company. If so, these contracts are made a part of this Plan document, and the contracts and Plan document should be construed as consistent, if possible. If the terms of this Plan document conflict with the terms of such insurance contract or other governing document, then the terms of the insurance contract or governing document will control, with the exception of defining eligible employees and dependents, which is determined by the Company, unless otherwise required by law.

4. Eligibility and Participation Requirements

Eligibility and Participation

An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 15. Reclassification from non-employee to employee status by a court or any agency or by the Company will not create any retroactive right to coverage.

Certain benefit programs require that you make an annual election to enroll for coverage. ***Generally, you cannot enroll, drop coverage, or change your or your dependents coverage under the plan except during annual Open Enrollment.*** However you may be able to add or drop coverage for yourself or a dependent during the plan year if you experience an event that triggers a HIPAA Special Enrollment Right (see discussion below) or if you have a Status Change Event (see Appendix C for an explanation of Status Change Events). Please review the rules for changing your benefits elections described in Appendix C very carefully as the rules regarding making benefits changes mid-year must be strictly enforced.

Information about enrollment procedures is provided by the Company. Information about when your participation begins in various benefit programs is found under Section 15. You must follow any required enrollment procedures. ***Always make sure the Company has your current home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.***

Eligible Dependent Status

Section 15 describes whether your spouse and or child can participate in a particular benefit program. Section 15 also describes any limits on such participation. For example, children covered under the Medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all). For specifics on eligibility for each benefit offered refer to Section 15. Note that the definition of dependent may be different for the different benefits offered under the Plan.

You cannot be covered both as an employee and as a dependent under the plan.

Full Time Status and the ACA

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if the coverage they offer is unaffordable or does not meet a minimum value standard. The Company determines full-time status using the “Monthly” method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 15.

Special Enrollment Provisions under HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for the Medical benefit program (or similar benefit programs providing medical benefits) may be available, usually if you lose medical coverage under certain conditions or when you acquire a new dependent by marriage, birth, or adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or a State Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse), and you or a dependent later becomes eligible for state “premium assistance” through Medicaid or a State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance. ***Medicaid and State Children's Health Insurance Program premium assistance are not available with respect to coverage under a health FSA or a high-deductible health plan. Thus, this special enrollment event will not apply to such plans.***

Coverage during Certain Leaves of Absence

Certain Federal (and State) statutes like the Family and Medical Leave Act (FMLA) require that eligibility for medical benefits continue for employees on those protected leaves of absence under the same terms as active employees. When wages continue during such a leave, your contributions will be deducted from those wages on a pre-tax basis. When such a leave is unpaid, you are still required to pay your portion of the premium. Your portion of the premium may be paid as regular monthly intervals during the leave on a post-tax basis.

You may also generally discontinue coverage at the beginning of such an unpaid leave and when you return your benefits will either be reinstated, or you may re-enroll for the remainder of the coverage period or plan year.

Human Resources must determine whether or not you are eligible for a statutory or other leave of absence.

Terms of Participation

Your participation and the participation of your spouse and dependents in a benefit program will terminate according to the terms of the specific benefit program. Generally, coverage for most benefit programs terminates on the last day of the month in which you terminate employment, but certain benefit programs may provide coverage only through the date your employment terminates. Please see Section 15 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth in the attached documents. You should consult Section 15 for a general summary and the attached documents for specific termination events and information.

Coverage may be terminated retroactively in the normal course of business due to a participant's termination of employment, nonpayment of premiums, loss of dependent eligibility or other, similar factors. When you or a dependent lose eligibility for benefits, regardless of whether or not you timely report that loss of eligibility, a change to any existing salary reduction election will be made automatically. To the extent that the coverage at issue does not allow for retroactive termination of that coverage and election to the date of the loss of eligibility, such changes will be prospective. If coverage can be terminated retroactively to the date of the loss of eligibility, or sometime thereafter, excess salary reduction contributions will be refunded on a post-tax basis to the date the termination of coverage can be made effective.

Any person claiming benefits under the Plan shall furnish the Company, any insurance company or other entity working on behalf of the Plan or a benefit program with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan or a benefit program. This may include but is not limited to providing social security numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

Knowingly enrolling an ineligible dependent in plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 15. If you have questions about whether a dependent is eligible you must contact Human Resources before enrolling that dependent.

COBRA Rights

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-

funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 15.

For the Health FSA benefit program, COBRA continuation coverage is available if your account is underspent (if the COBRA premium for the account (the monthly salary reduction election + 2%) for the remainder of the coverage period is less than the account's balance) but generally cannot extend beyond the end of the Plan Year (including any 2½ month grace period). COBRA continuation coverage will not be offered with respect to the Health FSA benefit program if your Health FSA is overspent, unless otherwise required by applicable law.

5. Summary of Plan Benefits

Benefits and Contribution

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 15. A summary of each benefit program provided under the Plan may be provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document).Note that some of the attached documents may be labeled as a "summary plan description." If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single "Summary Plan Description" for this Plan. Rather, this document constitutes the formal, single "Summary Plan Description."

The cost of the benefits provided through the benefit programs may be funded in part by Company contributions and in part by pre-tax and/or post-tax employee contributions. The Company will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Company reserves the right to change that determination.

The Company will make its contributions, if any, in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or your eligible family members from the Company's general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Company contributions to pay for the cost of such benefit program.

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime limits, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for preventive services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the attached documents.

Certain prescription drug benefits are considered “Creditable Coverage” under Medicare Part D. The attached documents provide details regarding this coverage and an annual notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

The Plan will provide benefits in accordance with the requirements of all applicable Federal laws regulating group health plans, such as COBRA, HIPAA, NMHPA,WHCRA and the Affordable Care Act. A brief summary of some of these laws is below.

Newborns' and Mothers' Health Protection Act (NMHPA) of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act (WHCRA) of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

Qualified Medical Child Support Orders

Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or "QMCSO." The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Michelle's Law: Mandate on Dependent Student Eligibility

Group health plans and health insurance issuers generally are prohibited from terminating a college student's health coverage on the basis of the child taking a medically necessary leave of absence from school or changing to a part-time status.

The leave of absence or reduction in hours must be medically necessary and must commence while the eligible student is suffering from a serious illness or injury and would otherwise lose coverage under the Plan because dependent age limitations (i.e., non-student dependent eligibility ending at age 18). The student must have been enrolled in the group health plan before the first day of the leave. There must also be a written certification by the student's physician indicating that the student is indeed

suffering from a serious illness or injury that necessitates the leave or change in enrollment status. The coverage under Michelle's Law must be extended for at least one year; however, coverage may end earlier for certain reasons, such as aging out of the Plan.

Lifetime and Annual Limits

Lifetime or annual limit on the dollar value of “essential health benefits” are no longer permitted under the major medical plans offered by the Plan. For more information on “essential health benefits” refer to the terms of policies and benefit program materials listed in Section 15. These documents are provided to you during enrollment and are available from Human Resources, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

6. Grandfathered Status under the Affordable Care Act

Non-Grandfathered Benefit Programs under the Affordable Care Act

The following benefit programs that provide health benefits are not “grandfathered health plans” under the Affordable Care Act:

- Kaiser Traditional HMO
- Kaiser Deductible HMO

These benefit programs must, under the Affordable Care Act, provide additional protections. The protections provided by the Affordable Care Act include the following:

Preventive Services covered at 100%

In-network preventive care services will be covered at 100% with no cost sharing (e.g., copayment, coinsurance percentage, deductible, etc.). Preventive services include those services outlined in the US Preventive Services Taskforce recommendations (services rated “A” or “B”). Please see the attached documents for the preventive services included at no cost share.

Non-Network Emergency Services covered as In-Network

Emergency services must be covered without the need for prior authorization, regardless of the participating status of the provider or facility, and at the in-network cost sharing level.

Access to Primary Care Physicians

The Affordable Care Act generally allows participants the right to designate any primary care provider who participates in the network and who is available to accept the participant and his or her family members. If the benefit program requires that a primary care provider be designated, but one is not designated, the benefit program or a health insurance issuer will designate one until the participant or family member makes such a designation.

- For children, you may designate a pediatrician as the primary care provider.

- You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

7. How the Plan Is Administered

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Plan Administrator is a named fiduciary within the meaning of ERISA § 402 and has full discretionary authority to administer the Plan, to interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan. However, insurers and parties that have entered into administrative service agreements (Third Party Service Providers or TPAs) assume sole responsibility for their performance under applicable policies or administrative services agreements and, under ERISA, may be fiduciaries with respect to their performance.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. (However, as noted below, one or more insurance companies may have these responsibilities with respect to fully-insured benefits.)

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Power and Authority of Insurance Company

As detailed in Section 15, certain benefits under the Plan may be fully insured. The insurance companies are responsible for: (1) determining eligibility for and the amount of any benefits payable under their respective benefit programs, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

Questions

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under any benefit program, please contact the Plan Administrator or the appropriate insurance company as applicable.

8. Circumstances Which May Affect Benefits

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible spouse and dependents) will cease when your participation in the Plan terminates. See Section 15. Your benefits will also cease on termination of the Plan.

Right to Recover Benefit Overpayments and Other Erroneous Payments

The Plan and its benefit programs (including any insurance company on behalf of a benefit program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the "Recipient") shall be responsible for refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Any benefit payments or reimbursements made by check must be cashed or deposited within one year after the check is issued. If any check or other payment for a benefit is not cashed or deposited within one year of the date of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. No funds will escheat to any state.

9. Amendment or Termination of the Plan

Amendment or Termination

The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Company as Plan sponsor, by a written instrument signed by an authorized individual. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in any attached documents from an insurance carrier. The policies and agreements may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

10. No Contract of Employment

The Plan is not intended to be, and may not be construed as, constituting a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

11. No Assignment

Except as may otherwise be specifically provided in this Plan, the benefit programs, or applicable law, an individual's rights, interests or benefits under this Plan or the benefit programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the benefit programs, and any such attempt shall be void.

Specifically, participants and beneficiaries covered under this plan cannot assign their rights to medical providers to pursue direct payment of claims either as the participant or beneficiaries' agent or under power of attorney. Under the terms of this plan, medical providers cannot take action enforcing a patient's right to recover benefits under ERISA or assert any claims under ERISA on behalf of patients, even where the patient(s) have assigned their rights to their medical providers.

In its discretion, the Plan Administrator may voluntarily pay (or cause to be paid) benefits directly to an out-of-network hospital, facility, or other health care provider on behalf of a participant or beneficiary covered under this plan, and such payment will not constitute an assignment of rights or benefits and will not be deemed a waiver of this no assignment provision as to that participant or beneficiary or any other participant or beneficiary covered under this plan.

12. Claims Procedure

Claims for Fully-Insured Benefits

For purposes of determining of the amount of, and entitlement to, benefits of the benefit programs provided under insurance contracts or policies, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to benefits.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form.

The insurance company will decide your claim in accordance with its reasonable claims procedures as required by ERISA.

See the appropriate certificate of insurance or booklet for details regarding the insurance company's claims procedures. You must fully follow and exhaust these claims procedures

before you can file a lawsuit in state or federal court. You may have a right to seek external review of your claims, if so noted in the applicable insurance contract or policy.

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the benefit programs which are self-funded, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan.

To obtain benefits from a benefit program which is self-funded you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence, as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. You may have a right to seek external review of your claims, if so noted in the applicable attached document for the self-funded benefit program.

See the appropriate benefits description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court.

The Role of Authorized Representatives

Under ERISA and the ACA participants and beneficiaries have the right to designate an Authorized Representative for certain purposes. These purposes are generally limited to requesting documents or other information on behalf of a participant or beneficiary or acting on their behalf during claims and appeals procedures that can follow an adverse benefits determination. In any situation that does not constitute an urgent care claim, to designate any third party as an Authorized Representative a participant or beneficiary must use the signed statement included as an appendix of this document with the required witness signature. A medical provider will not become a participant or beneficiary's Authorized Representative as a result of an attempt to secure an assignment of benefits. The Plan does not guarantee that any purported assignment will be valid under the terms of the Plan.

13. Statement of ERISA Rights

This Statement of ERISA Rights applies to those benefit programs which are subject to ERISA. Not all benefit programs which are part of this Plan will be subject to ERISA. The following benefit programs are not subject to ERISA: Cafeteria Plan and DCAP

Your Rights

As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all

documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;

- obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);
- receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report);
- continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Fiduciary Obligations

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to reimburse the Plan for any losses they have caused the program.

No Discrimination

No one, including the Company or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

Right to Review

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator review and reconsider your claim.

Filing Suit

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a court.

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of the internal claims and appeals procedure is required prior to filing suit.

If it should happen that benefit program fiduciaries misuse the Program's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S.

Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Questions

If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

14. General Information

COBRA

Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. For more information about COBRA please see Appendix A. You may also have state law continuation or conversion rights.

Subrogation and Reimbursement

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person shall cooperate fully with the Plan in the enforcement of the Plan’s subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person’s attorney’s fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan’s subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The plan is not required to contribute to any expenses or fees (including attorney’s fees or costs) incurred in obtaining the funds. The plan’s recovery will not be limited or reduced by doctrines

(equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 13 and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement provisions in the benefit program shall control. Otherwise, the provisions of this Section 13 shall apply and may supplement those contained in any benefit program.

The above provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully-insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

No Vesting of Benefits

Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any employee, former employee or covered person.

Waiver and Estoppel

No term, condition, or provision of this Plan or any benefit program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or benefit program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

Effect on Other Benefit Plans

Amounts credited or paid under this Plan or any benefit program shall not be considered to be compensation for purposes of any benefit program hereunder or any qualified or nonqualified pension plan maintained by the Company unless expressly provided in such benefit program or qualified or nonqualified pension plan, as applicable, or if required by applicable law. The treatment of amounts paid under this Plan or any benefit program for purposes of any other employee benefit plan maintained by the Company shall be determined under the provisions of the applicable employee benefit plan.

Severability

If any provision of this Plan or any benefit program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

Rebates

In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be:

☐ Considered an asset of the Company, not the Plan. The Company does not need to use such a rebate to benefit Employees, participants or beneficiaries. The Company can use such a rebate for the Company's own purposes

☐ An asset of the Plan in proportion to how much of the rebate relates to Employee, participant, or beneficiary contributions. The portion relating to Company contributions shall not be considered a Plan asset. The Company will have the ability to make certain assumptions or minor changes (such as rounding to the nearest $1 or $10) when determining the amount which is considered a plan asset. The Company shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Company. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.

☒ The entire amount shall be an asset of the Plan, to be used for the benefit of individuals covered by the Plan.

In all situations where ERISA applies the use of any ERISA-covered plan assets will be governed by applicable law, including but not limited to U.S. Department of Labor Technical Release 2011-04.

Controlling Law

This Plan shall be administered, construed, and enforced according to the federal law and the laws of the State of California, to the extent not preempted by federal law. However, with respect to a fully-insured benefit program, the applicable insurance policy or contract will control with respect to which state's laws apply.

15. Benefit Program Information

Summary of Eligibility and Participation Provisions

Note: If you have any questions about eligibility or participation, contact the Plan Administrator

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
Medical HMO	Fully-Insured / Kaiser Permanente	35962-0000, 35962-0003	Full time employees working a minimum of 20+ hours per week. Spouses and children generally are covered.	First day of the month following 30 days of employment.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Kaiser at: Member Services (800) 464-4000 (English) (800) 788-0616 (Spanish)
Health FSA	Self-Funded / Basic Pacific	4419-8003-9073	Full time employees working a minimum of 20+ hours per week. Spouses and children generally are covered.	First day of the month following 30 days of employment.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Basic Pacific at: Member Services PO box 2170 Rocklin, CA 95677 (916) 303-7090 (local) (800) 574-5448 (toll free)
Dental HMO & PPO	Fully-Insured / Sun Life	966953	Full time employees working a minimum of 20+ hours per week. Spouses and children generally are covered.	First day of the month following 30 days of employment.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Sun Life at: Dental Claims PO Box 2940 Clinton, IA 52733-2940 (800) 442-7742 PPO (800) 443-2995 DHMO
Vision	Fully-Insured / VSP	12261608	Full time employees working a minimum of 20+ hours per week. Spouses and children generally are covered.	First day of the month following 30 days of employment.	At the end of the month in which coverage is dropped or employment is	VSP at: Member Services 3333 Quality Drive - MS 131

[1] Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
					terminated. Continuation coverage usually is available.	Rancho Cordova, CA 95670 (800) 877-7195
Legal	Fully-Insured / Legal Shield	303090	Full time employees working a minimum of 20+ hours per week. Spouses and children generally are covered.	First day of the month following 30 days of employment.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Legal Shield: (800) 654-7757
EAP	Fully-Insured / Claremont	144660	Full time employees working a minimum of 20+ hours per week. Spouses and children generally are covered.	First day of the month following 30 days of employment.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Anita Ivy from Claremont at: (510) 995-1122 Member services: (800) 395-1616
Basic Life/ AD&D	Fully-Insured / Reliance Standard	167300	Full time employees working a minimum of 20+ hours per week. Spouses and children generally are covered.	First day of month following one month of employment.	Date of termination.	Reliance Standard at: Disability Claims (800) 351-7500
LTD	Fully-Insured / Reliance Standard	134802	Full time employees working a minimum of 20+ hours per week. Spouses and children generally are covered.	First day of the month following 30 days of employment.	Date of termination.	Reliance Standard at: Disability Claims (800) 351-7500
Vol. Life/AD&D	Fully-Insured / Aflac	N/A	Full time employees working a minimum of 20+ hours per week. Spouses and children generally are covered.	First day of the month following 30 days of employment.	Date of termination.	Aflac at: (831) 801-7998

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
Vol. STD	Fully-Insured / Aflac	N/A	Full time employees working a minimum of 20+ hours per week. Spouses and children generally are covered.	First day of the month following 30 days of employment.	Date of termination.	Aflac at: (831) 801-7998
Accident, Hospital Indemnity, and Critical Illness	Fully-Insured / Aflac	N/A	Full time employees working a minimum of 20+ hours per week. Spouses and children generally are covered.	First day of the month following 30 days of employment.	Date of termination.	Aflac at: (831) 801-7998

Appendix A: COBRA Continuation

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan. The persons listed on page one of this notice have been identified by the Plan as qualified beneficiaries entitled to elect continuation coverage. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained from:

Pathways Home Health and Hospice
Human Resources
585 North Mary Ave
Sunnyvale, CA 94085

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to eighteen (18) months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to thirty-six (36) months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. The first page one of this notice provides the maximum period of continuation coverage available to the listed qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if (i) any required premium is not paid on time, (ii) if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (Note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act), (iii) if a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or (iv) if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Pathways Home Health and Hospice of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify Pathways Home Health and Hospice of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify Pathways Home Health and Hospice of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of the continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact Pathways Home Health and Hospice to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

Pathways Home Health and Hospice
Human Resources
585 North Mary Ave
Sunnyvale, CA 94085

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Pathways Home Health and Hospice Plan sends periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is

made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan. Your first payment and all periodic payments for continuation coverage should be sent to:

Pathways Home Health and Hospice
Human Resources
585 North Mary Ave
Sunnyvale, CA 94085

If information is available about alternative coverage (coverage in lieu of continuation coverage, or individual conversion rights), it will appear here: NONE AVAILABLE

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. You can get a copy of your summary plan description from:

Pathways Home Health and Hospice
Human Resources
585 North Mary Ave
Sunnyvale, CA 94085

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you sent to the Plan Administrator.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for the collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Department Clearance Officer, 200 Constitution Ave, N.W, Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0123.

Cal-COBRA Continuation Coverage for Certain California Insured Plans

Insured medical plans with Contracts based in California are required to offer COBRA-qualified beneficiaries who are enrolled in their plans and exhaust their 18 or 29 months of federal COBRA an additional period of continuation coverage for a combined total of 36 months of continuation coverage from the date federal COBRA began. The premium charged for this additional coverage (after the maximum COBRA period has expired) will generally be 110% of the current premium rate. Contact your insurance carrier for further information on Cal-COBRA. Your insurance carrier will be able to supply you with further information regarding how to enroll, deadlines for enrollment, premium amounts, and deadlines for submitting premiums.

Appendix B: Medicare Part D

Medicare Part D Notice

Important Notice from Pathways Home Health and Hospice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Pathways Home Health and Hospice and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Pathways Home Health and Hospice has determined that the prescription drug coverage offered by the Pathways Home Health and Hospice Group Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Pathways Home Health and Hospice coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under Pathways Home Health and Hospice Group Welfare Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Pathways Home Health and Hospice prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Pathways Home Health and Hospice and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Pathways Home Health and Hospice changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	July 1, 2025
Name of Entity/Sender:	Pathways Home Health and Hospice
Contact-Position/Office:	Human Resources
Address:	585 N. Mary Ave. Sunnyvale, CA 94085
Phone Number:	(408) 773-4327

Appendix C: Cafeteria Plan and FSA Provisions

Refer to the following pages for the separate Flexible Spending Account Summary Plan Description (SPD).

SUMMARY PLAN DESCRIPTION (SPD)
for the
CAFETERIA PLAN, and ACCOUNT PLANS

The Employer named below also serves as Plan Administrator:
PATHWAYS HOME HEALTH AND HOSPICE
585 N. Mary Ave.
Sunnyvale, CA 94085
The Employer accepts service of legal process.

Federal Tax ID: 94-2823240

ERISA Plan Number: 515

Plan Name: The PATHWAYS HOME HEALTH AND HOSPICE **Cafeteria Plan and Account Plans**

Group Name, if applicable: N/A

Plan Effective Date: 07/01/2025

Plan Year: 07/01 to 06/30

Account Plans included in this Plan: Dependent Care FSA, Healthcare FSA

Run Out - Number of Days: 92 days

Run Out for Terminated Participants- Number of Days After Your Eligibility Ends: 90 days (Healthcare FSA only)

Carryover Maximum: N/A

Grace Period: 2 months, 16 days

'You' and 'Your' refer to an Employee who has enrolled in at least one Qualified Benefit Plan for the current Plan Year, or has a carryover balance from an existing Account Plan, when a Carryover is allowed as indicated above. 'You' and 'Your' are also referred to as a 'Participant'.

Purpose. Your Employer has adopted this Plan to allow You to pay for benefit options (called Qualified Benefit Plans) for Yourself, Your spouse, and Your dependents via pre-taxed salary reduction contributions. You may choose from these "tax free" Qualified Benefit Plans in lieu of receiving taxable compensation. The Plan is intended to qualify as a "Cafeteria Plan" within the meaning of Section 125(d) of the Internal Revenue Code. This Plan allows You to reduce Your taxable income in direct proportion to (a) Your contribution to the cost of Your elected Qualified Benefit Plans and (b) Your contribution to any Account Plan.

Qualified Benefit Plans. A Qualified Benefit Plan is a tax advantaged Plan pursuant to Section 125(f) of the Internal Revenue Code. The list of Account Plan(s) made available for the current Plan Year is provided above. The list of other Qualified Benefit Plans is provided in the Enrollment Materials provided by Your Employer at the time of enrollment, expressly incorporated by reference into this SPD.

If You are not eligible to participate in this Plan but are allowed to participate in any Qualified Benefit Plan then Your costs will be paid with taxable income and Your compensation will not be reduced by the Employer.

Employer Contributions. Your Employer may provide additional contributions in the way of cash or spending credits that You may use for Qualified Benefits Plans and/or other limited purposes as specified in the Enrollment Materials. These Employer contributions will continue to be provided to You while on approved FMLA Leave to the same extent as they would be provided to an Employee actively at work.

Enrollment Materials. The Enrollment Materials are expressly incorporated by reference into this SPD and include benefit guides and summary benefit descriptions that provide the following detail for the Qualified Benefit Plans offered by Your Employer:

1) The amount of Your Employer's contribution (if any) , the rules regarding how You can use that contribution and any limitation on the use of that contribution set by Your Employer;
2) Complete detailed schedules of benefits, and all exclusions and limitations on benefits including subrogation rights and instances in which benefits will be coordinated with other sources of payment;
3) Provisions governing the use of network providers, the composition of the provider network and whether, and under what circumstances, coverage is provided for out-of-network services;
4) The procedures governing claims for benefits including procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims in the case of any applicable time limits, and remedies available under the Plan for the redress of claims which are denied in whole or in part (including procedures required under Section 503 of Title I of the Act). Additional detail required by law for specific claims and appeals will be furnished as separate documents without charge;
5) Cost-sharing provisions including any deductibles, coinsurance and copayment amounts for which the Participant or beneficiary will be responsible;
6) Any annual or lifetime caps and all other limits on benefits;
7) The extent to which preventive services are covered;
8) Whether, and under what circumstances, existing and new drugs are covered;
9) Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;
10) Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
11) Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under a Benefit Plan;
12) A general description of the provider networks applicable to each Benefit Plan. A complete listing of providers in a network will be furnished to Participants and beneficiaries as a separate document at no charge;
13) Any circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture, suspension, offset, reduction, or recovery of any benefits; and,
14) Whether and to what extent benefits under the Benefit Plan are guaranteed under a contract or policy of insurance issued by the Insurance Company, and the nature of any administrative services (e.g., payment of claims) provided by the Insurance Company or Third-Party Administrator.

An Employee's right to enroll in and maintain coverage under the Qualified Benefit Plans are described in detail in the Enrollment Materials provided by the Employer, including:

1) Under what circumstances a spouse, dependents and other persons may be enrolled including any proof of a relationship needed to meet the eligibility requirements (note that group health Plans are required to cover dependent children placed with a Participant for adoption under the same terms and conditions as apply in the case of dependent children who are Your natural children);
2) The existence of any waiting periods and how they are applied;
3) When enrollment is allowed and a description of the enrollment procedures;
4) When coverage will be effective and when it will end including the events that can occur that will terminate coverage;
5) Details regarding when special enrollment rights allowing individuals who previously declined health coverage for themselves and their dependents have an opportunity to enroll (regardless of any open enrollment period). The Special Enrollment Notice, a copy of which was previously furnished to each Participant, also contains important information about the potential special enrollment rights including a 30 day time limit for requesting the enrollment. You can contact Your Benefits Coordinator to receive an additional copy of that notice; and,
6) Details regarding when special enrollment rights for an employee who is eligible, but not enrolled for coverage (or a dependent of the employee if the dependent is eligible, but not enrolled) when either:
   (a) The employee or dependent were covered under a Medicaid Plan or under a State Child Health Plan (SCHIP) and that coverage is terminated as a result of loss of eligibility; or,
   (b) The employee or dependent becomes eligible for premium assistance from Medicaid or SCHIP (including assistance under any waiver or demonstration project conducted under or in relation to Medicaid or SCHIP).

This Plan defines an eligible Employee to be an individual classified by the Employer as a common-law employee who is typically on the employer's W-2 payroll. 'Employees' does not include self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

Administration. Your Employer acting as the Plan Administrator has sole discretionary powers and is responsible for the administration of this Plan and the Qualified Benefit Plans. Should You need to see any records or have any questions regarding these Plans, contact Your Employer. Your Employer has sole discretionary authority (a) to interpret the Plan in order to make eligibility and benefit determinations, and (b) to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan. The Plan Administrator has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time.

No Continued Employment. No provisions of the Plan or this SPD grant any Employee any rights of continued employment with the Employer or in any way prohibit changes in the terms of employment of any Employee covered by the Plan.

ACCOUNT PLANS

The Account Plans offered for the current Plan Year are listed above on the first page of this SPD. Your Employer appoints BASIC as its Service Provider to maintain certain Account Plan records and to be responsible for the Account Plan's day-to-day administration. BASIC is not a Plan Administrator and has no discretionary authority over the Plan.

The Participant Reference Guide. The Participant Reference Guide which is incorporated by express reference into this SPD, includes all the information You need to access Your Account Plans and submit requests for reimbursement. By signing into Your online Account Plan, You may access information about Your enrollment, available funds, annual election, total contributions, and total reimbursements.

Age Requirement. No maximum age requirement may be imposed for participation in an Account Plan.

Re-employment of Former Employees. A former Employee rehired within thirty (30) days of termination will immediately be reinstated into their original Account Plan elections. A former Employee rehired after thirty (30) days of termination will be allowed to make new Account Plan elections.

Excess Payments. Upon any benefit payment made to an Accountholder in error under an Account Plan, said Accountholder will be informed and required to repay the errant amount. This includes and is not limited to amounts over the Accountholder's annual election, amounts for services that are determined to be ineligible, or when adequate documentation to substantiate a paid Request for Reimbursement (RFR) upon request is not provided. The Employer may take reasonable steps to recoup the excess payment including withholding the amount from future salary or wages and subtracting from future benefit reimbursement(s). You will be allowed to submit valid claims to offset any amount due.

Non-Assignment of Benefits. No Accountholder or beneficiary may transfer, assign or pledge any Account Plan benefits except as may be required pursuant to a "Qualified Medical Child Support Order" (which provides for Plan coverage for an alternate recipient), other applicable law, or payment made directly to a healthcare provider.

Termination Of Participation. Accountholders are enrolled in the Account Plan for the entire Plan Year or the portion of the Plan Year remaining after enrollment. You will automatically cease to be an Accountholder due to the following events:

1) Your death, resignation or termination of employment with the Employer;
2) This Plan terminates;
3) You fail to pay any required premium (including payment by salary reduction) under the Plan;
4) You no longer meet the requirements for eligibility in the Plan; or,
5) You revoke Your election under a qualifying change in status event.

Your actual termination date due to these events will vary depending on the Account Plan and Your Employer's Account Plan design. Check with Your Employer for Your actual termination date. After Your termination in an Account Plan, you can only be reimbursed for services rendered prior to your eligibility end date and submitted before the end of the Run Out Period specified on the first page of this SPD.

Change In Status Events. The laws governing Account Plans generally do not allow You to change Your benefit and contribution elections during a Plan Year (except for Health Savings Accounts; see below). Your elections are irrevocable and any balance in Your account at the close of the Plan Year is forfeited and becomes the property of Your Employer (refer to the first page of this SPD to see if there is a Grace Period or Carryover). This irrevocable election rule does not apply if You experience a qualifying change in status event. The election change request must be on account of and consistent with the change in status event.

Any request to change Your election must be submitted in writing within 30 days of the occurrence of a change in status event. The new benefit elections start after the change in status event has occurred and the paperwork has been filed. This Plan is intended to allow any change in status event that is allowed by the IRS. The following change in status events are applicable:

1) A change in legal marital status (marriage, death of spouse, divorce, legal separation and annulment).
2) The adoption, birth, or death of a child or dependent.
3) Dependent satisfies or ceases to satisfy dependent eligibility requirements.
4) The change in employment status of You, Your spouse or dependent.
5) Change in Your residence. *
6) Beginning or ending adoption proceedings.
7) Automatic changes upon cost increases or decreases. *
8) Significant cost increases. *
9) Significant curtailment of coverage. *
10) Addition or elimination of similar benefits package option. *
11) Change in coverage of a spouse or dependent under an employer Plan. *
12) FMLA.
13) HIPAA special enrollment rights. *
14) COBRA qualifying event.
15) Loss of group health coverage sponsored by governmental or education institution. *
16) A judgment, decree or order requiring coverage for a spouse or child.
17) Medicare or Medicaid entitlement.

18) Termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage. *
19) Eligibility for Employment Assistance under Medicaid or SCHIP. *
20) Exchange Event – A loss of eligibility under the terms of the Plan due to a reduction in hours (less than 30) – even when the Employer allows the coverage to continue in effect during the 'Stabilization Period' to satisfy the Affordable Care Act coverage requirements. *
21) Exchange Event – Exchange enrollment during an Exchange open enrollment period or special enrollment period. *
22) Exchange Event – Exchange enrollment by one or more of the participant's dependents and/or spouse who are enrolled in the Employer provided group health insurance plan during an Exchange special enrollment period or open enrollment period. (Effective January 1, 2023) *

**These qualifying change in status events do not apply to the Healthcare FSA.*

Notes:

1) If You are making tax free contributions to a Health Savings Account (HSA) under this Plan, You do not need a change in status event to change Your HSA election. You may prospectively change Your HSA election at any time during the Plan Year.
2) For the termination of Medicaid or SCHIP coverage and eligibility for employment assistance under Medicaid or SCHIP, the Employee must request the group health benefit change no later than 60 days after the date of termination or after the date eligibility is determined under Medicaid or SCHIP.

Grace Period or Carryover. As a terminated Accountholder, You are not eligible for the Grace Period or Carryover (when offered by Your Employer) unless You are an active Accountholder in the Plan and Your Paid Coverage Period continues through the last day of the Plan Year.

The Family And Medical Leave Act ('THE FMLA') and Unpaid Leave. The FMLA requires employers with 50 or more employees to provide unpaid leave for eligible employees under circumstances that are prescribed by applicable federal law, including the Family and Medical Leave Act of 1993 (29 U.S.C. 2611) as amended.

The payment option(s) for coverage while on unpaid Family Medical Leave Act leave and for unpaid leave for Healthcare Account Plans are:

1) Pre-pay. Under this option, you will pay Your election amounts that will be due during your leave, before your FMLA leave begins. The payments may be either pre-tax or after-tax, according to the terms of your Salary Reduction Agreement.
2) Pay-as-you-go. Under this option, You will pay your share of Your election amounts on the same schedule as if You were not on leave. If You fail to make payments under this Pay-as-you-go option, Your Employer is not required to continue coverage. However, if Your Employer chooses to continue coverage, Your employer is entitled to collect these amounts from you after You return from the FMLA leave.

If a Participant's coverage under the Plan ceased while on FMLA leave, the Participant will be entitled to resume coverage upon return from leave on the same participation basis in effect prior to the leave, or as otherwise required under the FMLA. The Participant will be entitled to elect reinstatement in the Plan at the coverage level that was in effect before the FMLA leave, with increased contributions if necessary to reach their annual election. Or, the Participant can continue with the amount withheld from the Participant's compensation on payroll-by-payroll basis equal to the amount withheld before the FMLA leave.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA). The first page of this SPD indicates whether this Plan includes a Healthcare Flexible Spending Account. All healthcare expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, (b) incurred by an Accountholder, Accountholder 's spouse, or dependent, (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit plan or account. Services and supplies must be for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Services and supplies that are beneficial" to an individual's general health" are not covered unless they are determined by a physician to be necessary to treat or alleviate a specific

physical or mental illness. Amounts paid for menstrual care products shall be treated as paid for medical care. Over-the-counter (OTC) products no longer require a prescription and can be reimbursed under this Plan.

Uniform Coverage Rule. The entire amount of your annual Healthcare FSA election is available to You for services rendered on any day of the Plan Year that you are covered by the Healthcare FSA.

Limitations and Exclusions. The following examples—even those recommended by a doctor—do not qualify as expenses eligible for reimbursement under the Healthcare FSA: insurance premiums; expenses for cosmetic procedures or cosmetic items; items that are for an Accountholder's general wellbeing; items the Accountholder would have purchased even if the Accountholder had no medical condition (for example, a toothbrush); vacation and travel expenses even if for rehabilitation or prescribed by a doctor; long-term care expenses that are not for actual medical care; expenses incurred in stockpiling over-the-counter items in quantities that could not reasonably be used during the current Plan Year.

Qualified Reservist Distribution**.** An Accountholder who is called to active duty in the US Armed Services and enrolled in the Healthcare FSA may elect to receive a Qualified Reservist Distribution of all or a portion of the unused balance in his/her individual Healthcare FSA subject to the requirements of Code Section 125(h) and the applicable regulations thereunder. The Employer may limit this distribution to the amount You have contributed to the account that has not been used to reimburse You for RFRs submitted.

Qualified Medical Child Support Order (QMCSO). The Plan will provide benefits in accordance with a QMCSO and adhere to the terms of any judgment, decree, or court order which (1) relates to the provision of child support related to health benefits for a child of an Accountholder in a group health Plan; (2) is made pursuant to a state domestic relations law; and (3) which creates or recognizes the right of an alternate recipient—or assigns to an alternate recipient the right—to receive benefits under the group health Plan under which an Accountholder or other beneficiary is entitled to receive benefits. Accountholders may obtain, without charge, a copy of the Plan's procedures from the Plan Administrator.

Family and Medical Leave Act (FMLA). If You go on a qualifying leave under FMLA, to the extent required by the FMLA, Your Employer will continue to maintain Your benefit package options providing health coverage (including the Healthcare FSA) on the same terms and conditions as if You were still active (that is, Your Employer will continue to pay its share of the contribution to the extent You opt to continue coverage). Your Employer may require You to continue coverage while You are on paid leave (as long as Accountholders on non-FMLA paid leave are required to continue coverage). If so, You will pay Your share of the contributions by the method normally used during any paid leave.

If Your coverage ceases while on FMLA leave, You will be permitted to re-enter the Plan upon return from such leave, and to participate in the Plan on the same basis as You had been prior to the leave or as otherwise required by the FMLA. You may elect reinstatement in the Plan at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a reduced pro-rata coverage level for the period of FMLA leave during which You did not make contributions. Your coverage may be automatically reinstated as well, but only if coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

Unpaid FMLA Leave**.** If You are going on unpaid FMLA leave and You opt to continue Your Medical and Dental Insurance Benefits and Healthcare FSA Benefits, then You may pay Your share of the contributions in one of three ways:

(1) Prepay. Your share of contributions due during Your leave may be paid either pre-tax or after-tax before Your leave begins provided any pre-tax pre-payments do not fund coverage for the next Plan Year.
(2) Pay-as-You-go. Your share of contributions will be paid on the same schedule as if You were not on leave or under another schedule. Per the Department of Labor regulations, if You fail to make payments under this option, Your Employer is not required to continue coverage. If Your Employer chooses to make payment and thereby continue coverage, Your Employer is entitled to recoup these amounts from You after You return from leave.
(3) Catch-up. Your Employer may advance Your share of contributions while You are on leave. Upon Your return from leave, Your Employer may recover the advanced amounts on either a pre-tax or after-tax basis. Check with Your Employer to determine if this option is available under Your Plan.

Non-FMLA Leave**.** If You go on an unpaid leave of absence that does not affect eligibility, then You will continue to participate and the contribution due from You will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If You go on an unpaid leave that affects eligibility, then the Change in Status rules will apply.

Military Leave**.** If You take a leave of absence due to military service, You may continue coverage under this Plan as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Health Savings Account (HSA): If You contribute to a Health Savings Account (HSA) then You may only enroll in a ***Limited Purpose Healthcare FSA*** **(LPFSA**). Qualified Expenses under an LPFSA are limited to dental and vision services or supplies excluded from coverage under Your high deductible health plan, or unpaid amounts incurred after the HDHP statutory annual deductible has been satisfied. The LPFSA will not provide reimbursement for any other service or supply regardless of whether that service or supply is allowed by the IRS as a medical expense or allowed under a General-Purpose Healthcare FSA.

HealthCare FSA Continuation Coverage Rights Under COBRA. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, ("COBRA") continuation shall not apply to any group health Plan of the Employer for any calendar year if all employers maintaining such Plan normally employed fewer than twenty (20) Employees on a typical business day during the preceding calendar year. Government entities are subject to the same continuation coverage under the Public Health Services Act. This Summary Plan Description describes Your rights for the Healthcare FSA. Your rights under any of the other Qualified Benefits Plans offered by Your Employer are described in the Summary Plan Description(s) for that Plan and may be obtained from Your Plan Administrator.

If You elect to participate under the Healthcare FSA and are considered an Accountholder on the day before experiencing a qualifying event, COBRA continuation ends on the last day of the Plan Year in which the qualifying event occurred. Further, COBRA continuation coverage will not be offered if on the day of Your qualifying event, the amount of Your annual election less any reimbursed payments is less than the amount of premium required to continue the Healthcare FSA Plan until the end of the Plan Year. COBRA continuation under an excepted Healthcare FSA Plan is available until the end of the Plan Year in which the qualifying event occurs.

An Accountholder who experiences a qualifying event is considered a qualified beneficiary. When a qualified beneficiary experiences a qualifying event, they will be sent a notification explaining their rights to elect COBRA continuation coverage. Your Employer has 44 days from the date of the loss of coverage in which to send the COBRA Election Notice. A qualified beneficiary who wishes to continue coverage must notify the Plan Administrator of their desire to continue coverage within sixty days of either the date of notification or date of loss of coverage, whichever is later. If the Plan Administrator does not receive notification within this time period, You will lose Your right to elect continuation coverage. Finally, qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date that termination from the Plan would have occurred.

COBRA continuation is available until the end of the Plan Year in which the qualifying event occurs. The premium charged for the continuation coverage will be 102% of Your monthly contribution. The Employer may require the COBRA payments be apportioned for the remainder of the Plan Year.

Listed below are qualifying events.

(1) Termination of employment (for reason other than "gross misconduct"); and
(2) Reduction of employee's work hours.

If You have questions about Your COBRA continuation coverage, You should contact Your Employer or You may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA); addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT. The first page of this SPD indicates whether this Plan includes a Dependent Care Flexible Spending Account. This account provides employees with tax free dependent care assistance

only when the assistance is necessary for the Accountholder to leave the home to engage in activity directly related to his/her employment. Qualified expenses under the Dependent Care FSA include any expenses that You could take as a credit against tax on Your income tax form for the care of a Qualified Person. Benefits are provided only to the extent of Your payroll deduction on the date the RFR is processed. The tax laws further limit how much You may contribute to this account.

Under the law and the terms of the Plan, You may defer no more than the lesser of Your actual income for the year (or, if You are married and it is less, Your spouse's actual income) or $5000 per year to this Program. A married Accountholder who files separate tax returns is limited to $2500 per year. A married Accountholder who files joint returns can split this limit as they see fit.

HEALTHCARE PREMIUM (NESP) REIMBURSEMENT ACCOUNT. The first page of this SPD indicates whether this Plan includes a Healthcare Premium (NESP) Reimbursement Account. This account provides reimbursement for premiums You paid for employee-owned health insurance policies. Employer-provided insurance Plans and coverage offered through the Marketplace, (a state or federal Plan under the Affordable Care Act), do not qualify. Premiums eligible for reimbursement are for a period in which You were a covered Accountholder under this account.

REIMBURSEMENT DENIALS FOR ACCOUNT PLANS

Reimbursements under the Healthcare FSA, Limited Purpose Healthcare FSA, Dependent Care FSA, or Healthcare Premium (NESP) Reimbursement Account. The RFR procedure described below will apply if (a) a RFR under the Healthcare FSA, Limited Purpose Healthcare FSA, Dependent Care FSA, or Healthcare Premium (NESP) Reimbursement Account components of the salary reduction Plan is wholly or partially denied, or (b) You are denied a benefit under the salary reduction Plan due to an issue germane to Your coverage under the Plan.

If Your RFR is denied in whole or in part, You will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received Your request. (This time-period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where an RFR is incomplete.) The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected. When an RFR is incomplete, the extension notice will also specifically describe the required information, will allow You 45 days from receipt of the notice in which to provide the specified information, and will effectively suspend the time for a decision on Your RFR until the specified information is provided.)

Notification of a denied RFR will detail:

- specific reason(s) for the denial;
- specific Plan provision(s) on which the denial is based;
- a description of any additional material or information necessary for You to validate the RFR and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if You wish to appeal the Plan Administrator's decision, including Your right to submit written comments and have them considered, Your right to review (upon request and at no charge) relevant documents and other information, and Your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of Your RFR.

Appeals. If Your RFR is denied in whole or part, then You (or Your authorized representative) may request review upon written application to the Plan Administrator. Your appeal must be made in writing within 180 days after Your receipt of the notice that the RFR was denied. If You do not appeal on time, You will lose both the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that You feel Your RFR should not have been denied. It should include any additional facts and/or documents that You feel support Your RFR. You will have the opportunity to ask additional questions and make written comments, and You may review (upon request and at no charge) documents and other information relevant to Your appeal. The address to use when filing an appeal will be included in the benefit or enrollment denial letter.

Decision on Review. Your appeal will be reviewed, and a determination made within a reasonable time, defined as not later than 60 days after receipt of Your appeal. If the decision on review affirms the initial denial of Your RFR, You will be furnished with a Notice of Adverse Benefits Determination on Review, which shall set forth the following:

- specific reason(s) for the decision on review;
- specific Plan provision(s) on which the decision is based;
- a statement of Your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to You upon request; and
- a statement of Your right to bring suit under ERISA §502(a) (where applicable).

NOTICES REQUIRED BY LAW

Special Rights on Childbirth. Under Federal law, group health Plans may not restrict benefits for any hospital length of stay in connection with childbirth for (either mother or newborn child) to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above period. In any case, under Federal law a provider may not be required (by Plan or insurer) to obtain authorization from the Plan for prescribing a length of stay up to 48 hours (or 96 hours).

ERISA Rights. An Account Plan that reimburses the Participant for medical services is subject to the Employee Retirement Income Security Act of 1974 (ERISA). An Account Plan that reimburses only medical premium is not subject to ERISA. Some of Your basic rights under ERISA are described below. Your rights under ERISA and other federal and state law as related to other Qualified Benefit Plans You elected are fully detailed in the Summary Plan Descriptions that are maintained by Your Employer for those Plans.

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration [sic Employee Benefits Security Administration]. Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. Continue health care coverage for Yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your dependents may have to pay for such coverage. Review this summary Plan description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.
Reduction or elimination of exclusionary periods of coverage for preexisting conditions under Your group health Plan, if You have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from Your group health Plan or health insurance issuer when You lose coverage under the Plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage. Without evidence of creditable coverage, You may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after Your enrollment date in Your coverage.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Participants and

beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a (pension, welfare) benefit or exercising Your rights under ERISA.

Enforce Your Rights. If Your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance with Your Questions. If You have any questions about Your Plan, You should contact the Plan administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

INTRODUCTION and INSTRUCTIONS

Materials, Use and Limited License
BASIC is granting a non-exclusive, non-assignable, limited license to use this Plan Document only in connection with the provisions of the Subscription Services. It is understood that the Plan Document and related materials are the confidential property of BASIC, they are not "work for hire", and no additional rights to use the Materials are granted. The Purchaser is responsible for its use and the protection of the confidentiality of Materials and shall be liable for any unauthorized use or disclosure.

Effect of Termination
The terms of the limited license to use this Plan Document continue after the termination of any or all agreements between BASIC and the Purchaser.

Instructions
This Plan Document does not stand alone.

- This Plan Document incorporates by reference your Enrollment Materials. Place a copy of your entire enrollment package for each enrollment period, along with any changes that are communicated during the year, in a file with this Plan Document for easy access for participant requests or for an audit.
- This Plan Document refers to the Summary Plan Description for specific details such as the plan year, plan name and other necessary demographics. These instances are spelled out in the Plan Document.
- Any amendment made by competent legal counsel should be attached to this Plan Document. BASIC does not need to review such amendments. BASIC will have no liability for any losses or penalties related to such amendments.

This Plan Document should be saved each year with a copy of the Summary Plan Description and Enrollment Materials attached for ease in responding to any audits or Participant requests.

Important Notice
This Plan Document is intended as a prototype Plan Document for use with a BASIC Subscription Service. BASIC and its representatives are not attorneys and do not provide legal advice. Any questions regarding state or local requirements, and any requests for revisions or additional terms should be sent to your benefit advisor or legal counsel.

Adoption
This Plan Document is adopted by the Purchaser by its acts to download and save this Plan Document per these instructions. The Purchaser is advised to inquire internally and follow any and all specific or formal requirements for the adoption of a benefit plan.

PLAN DOCUMENT
For the
CAFETERIA PLAN, and ACCOUNT PLANS

Article I: Table of Contents

Article VIII: Account Plans

Article II: Purpose

2.01 **Adoption and Purpose.** The Employer adopts this Cafeteria Plan under the terms and conditions set forth in this Plan Document as well as through the Enrollment Materials that are expressly incorporated by reference into this Plan Document. The plan allows Participants to elect between cash compensation or certain nontaxable Qualified Benefits Plans maintained by the Employer as identified in the Enrollment Materials. The Employer intends that this plan qualify as a Cafeteria Plan under Section 125 of the Internal Revenue Code. If any term in this Plan Document is found to be in conflict with federal or state law, the term will automatically be amended to comply with the federal or state law. Neither the Employer nor its designated representatives makes any commitment or guarantee that any amounts elected or paid for the benefit of a Participant will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant.

2.02 **Plan Detail and Demographics.** This Plan Document expressly incorporates by reference the following demographics from the Summary Plan Description: The Plan Name; the Plan Sponsor's name and address; the Plan Administrator's name and address, and the Plan Year.

Article III: Definitions

3.01 **Change in Status Event.** A Change in Status Event allows a Participant to revoke or change his/her pre-tax election during the Plan Year, and outside of the scheduled open enrollment period. The Employer allows all of the Change in Status Events published by the IRS for this type of plan under 26 CFR 1.125-4, as amended. A Participant who becomes eligible under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") for coverage under an accident or health benefit offered by the Employer will be allowed to make a consistent election, or election changes under this Cafeteria Plan.

Additional 'Change in Status' Event Election Change for Group Health Plan Coverage. Effective January 1, 2023, provided that the conditions set forth below are satisfied, this election change provision permits You to prospectively revoke Your election for family coverage under Your Employer's group health insurance plan in order to allow one or more Related Individuals (as defined below) to enroll in a Qualified Health Plan through a Health Insurance Exchange ("Exchange") in the individual market ("Marketplace Coverage"). A "Related Individual" is any individual who is enrolled in the Employer provided group health insurance plan because of a relationship to You.

You may prospectively revoke an election of family coverage under Your Employer's group health insurance plan, provided the following conditions are satisfied:

(1) One or more Related Individuals are eligible for a special enrollment period to enroll in Marketplace Coverage pursuant to guidance issued by the Department of Health and Human Services (DHS) and any other applicable guidance, or one or more already-covered Related Individuals seeks to enroll in a Marketplace Coverage during the Exchange's annual open enrollment period; and

(2) The revocation of the election of coverage under Your Employer's group health insurance plan corresponds to the intended enrollment of the Related Individual(s) in Marketplace Coverage for new coverage that is to be effective beginning no later than the day immediately following the last day of the coverage that is being revoked pursuant to Your election pursuant to this Additional Change in Status Event.

If You do not enroll in Marketplace Coverage, You must elect self-only coverage (or family coverage including one or more already-covered Related Individual) under Your Employer's group health insurance plan.

When making a revocation election pursuant to this Additional Change in Status Event, You will be required to represent that You and/or Related Individual(s) have enrolled or intend to enroll in Marketplace Coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked in accordance with these Additional Change in Status Event provisions and Your Employer may rely on such representation.

3.02 **Code.** The Internal Revenue Code of 1986, as amended from time to time.

3.03 **Compensation.** All the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction

agreement which are not includable in gross income under Sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the Internal Revenue Code.

3.04 **Dependent.** For the purpose of the tax advantages available under this plan, a Dependent is an individual who is a dependent of a Participant within the meaning of Section 152(a) of the Internal Revenue Code, and any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year). For the purposes of the tax advantages available under Qualified Benefit Plans that provide accident and health benefits as defined under Sections 105 and 106 of the Code, a Dependent is determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof and includes any child (as defined in Code § 152(f)(1)) of the Participant who at the end of the taxable year has not attained age 27.

3.05 **Eligible Employee.** An Employee who is eligible to participate in the one or more Qualified Benefits Plans sponsored by the Employer, limited to an "Employee" as defined below in Section 3.06, who meets additional requirements defined in the Employer's Enrollment Materials and not including the following:

(a) Employees who are Non-Resident Aliens (within the meaning of Section 7701(b)(1)(B) of the Internal Revenue Code) who are deriving no earned income (within the meaning of Section 911(d)(2) of the Code) from the Employer which constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Code); and,

(b) Employees who are self-employed individuals (as described in Section 401(c) of the Internal Revenue Code) including sole proprietors, partners in a partnership, or more than 2% owners of subchapter "S" Corporations. This exclusion applies to the Spouse, children, parents, and grandparents under the Code Section 318 attribution rules.

If an Employee is not eligible to participate in this plan and allowed to participate under any Qualified Benefits Plan, then the Employee cost will be paid with taxable income, and the Compensation will not be reduced by the Employer.

3.06 **Employee.** An Employee is a person who is currently or hereafter employed by the Employer, or by any other Employer aggregated under Sections 414(b), (c), (m), (n), or (o) of the Internal Revenue Code and the regulations thereunder, including a leased Employee subject to Section 414(n) of the Code.

3.07 **Employer.** The Employer adopting this plan and any affiliate or subsidiary that, with the consent of the Employer becomes an Employer, by adopting the plan, or any successor business organization that assumes the obligations of the Employer.

3.08 **Enrollment Materials.** The Employer will provide written Enrollment Materials at each enrollment period and during the Plan Year for midyear enrollees. The Enrollment Materials will provide the specific process for enrollment in the Qualified Benefits Plans. The Enrollment Materials are expressly incorporated by reference into this Plan Document.

3.10 **Participant.** Any person who has been or is an Eligible Employee and who qualifies to participate and enrolls in a Qualified Benefits Plan.

3.11 **Plan Year.** Commencing on the first day of the Plan Year and each anniversary thereof, except that the first Plan Year may include a period of fewer than twelve (12) consecutive months.

3.12 **Qualified Benefits Plan.** Employer-sponsored plans that are allowed tax advantages under this plan pursuant to Section 125(f) of the Internal Revenue Code. The list of Qualified Plans available under this Cafeteria Plan is provided in the Enrollment Materials.

3.13 **Spouse.** Any individual who is legally married to a Participant under applicable state law.

Article IV: Administration

4.01 **Employer's Duties.** In addition to any rights, duties or powers specified in this Plan Document, the Employer will have the following rights, duties, and powers:

(a) to interpret the plan, to determine the amount, manner and time for payment of any benefits under the plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the plan;

(b) to adopt and apply any rules or procedures to ensure the orderly and efficient administration of the plan, and from time to time, amend or supplement such rules and regulations;

(c) to determine the rights of any participant, Spouse, or Dependent to benefits under the Qualified

Benefit Plans;

(d) to develop appellate and review procedures for any Participant, Spouse, or Dependent denied benefits under the plan;

(e) to maintain records, it may require in connection with the proper administration of the plan;

(f) to employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(g) to correct any defect, supply any omission, or reconcile any inconsistency in the plan in such a manner and to such extent as it shall be deemed expedient to administer the plan;

(h) to amend or terminate this plan.

4.02 **Information to be Provided to Employer.** The Employer, or any of its agents, will collect employment records of Participants under the plan. These records will include any information the Employer may need for the proper administration of the plan. A Participant will furnish the Employer the data the Employer reasonably requests to ensure the proper and efficient administration of the plan.

4.03 **Interpreting Plan Terms.** Any interpretation of any provision of this plan made in good faith by the Employer as to the terms of this plan is final and will be binding upon the parties.

4.04 **Misstatements.** Any misstatement or other mistake of fact will be corrected as soon as reasonably possible upon notification to the Employer and any adjustment or correction attributable to such misstatement or mistake of fact will be made by the Employer as he considers equitable and practicable.

4.05 **Review Procedures.** An Employee or his/ her authorized representative can appeal a decision made to deny enrollment in a Qualified Benefits Plan or a decision to disallow an election change by sending a written request for an appeal to the Employer within 60 days of the decision to deny enrollment or an election change. The appeal will be performed in a manner that does not afford deference to the initial determination and will be conducted by the Employer or designee. A Participant can request, free of charge, reasonable access to, and copies of, all documents and records relevant to the decision. Benefit appeals for denied claims are addressed in the Qualified Benefits Plan descriptions provided by the Employer.

4.06 **Medical Child Support Orders.** The Employer will adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which complies with federal or applicable state law, including 29 USC Sec. 1169 relating to Qualified Medical Child Support Orders (QMCSO), including any federal regulations or state laws relating to the same. On the date coverage is provided as directed by a QMCSO the Employee-parent will become eligible to participate in this plan in order to pay his/her share of the cost of the coverage on a pre-tax basis.

4.07 **The Privacy Rule.** Protected Health Information ("PHI") is defined as information that is created or received by the Employer which relates to the past, present, or future physical or mental health or condition of a Participant; or, the provision of healthcare to a Participant; or the past, present, or future payment for the provision of healthcare to a Participant; and that identifies the Participant. The test is whether there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased.

- **Access to PHI:** The Employer's access to PHI is restricted to the minimum information necessary to administer the Healthcare FSA. This includes obtaining Participant elections and reimbursements for payroll administration. The Employer has access to PHI submitted for claims reimbursement when that claim is on an appeal from an adverse decision. Only the Benefits Coordinator and Employees trained in the federal privacy rule will have access to the PHI.
- **Permitted and Required Uses and Disclosures of PHI by the Employer:** The Employer may use and disclose PHI for plan administration functions only as permitted and required by this Plan Document, or as required by law. The Employer will not use or disclose PHI for employment-related actions or in connection with any other Employee benefits plan. When necessary, the Benefits Coordinator will disclose the PHI to consultants and experts as required by the Department of Labor for a full and fair review or to perform plan non-discrimination testing as required by law.
- **Complaints:** If a Participant has any complaints regarding the way in which the Employer has handled PHI said Participant may complain to the Benefits Coordinator. No response from the Benefits Coordinator is required. A copy of this complaint procedure shall be provided to the Participant upon request. The Benefits

Coordinator will keep a copy of the complaint, applicable documentation, and disposition if any, for a period of 6 years from the end of the Plan Year in which the act occurred.

- **No Retaliation:** No Employee will intimidate, threaten, coerce, discriminate against, or take other retaliatory action against Participants for exercising their rights, filing a complaint, participating in an investigation, or opposing any improper practice under the federal Privacy Rule.
- **Firewall:** The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf of the group health plan; and ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information.

  Employer will do the following:
  (1) Ensure that any subcontractors or agents to receive PHI agree to the same restrictions described above,
  (2) report to the health plan any use or disclosure that is inconsistent with this Plan Document or the federal Privacy Rule,
  (3) make the PHI information accessible to the Participants,
  (4) allow Participants to amend their PHI,
  (5) provide an accounting of its disclosures of PHI as required by the Privacy Rule,
  (6) make its practices available to the Secretary of Health and Human Services for determining compliance, and
  (7) return and destroy all PHI when no longer needed, if feasible.

4.08 **The Federal Security Rule.** This rule is intended to bring the plan into compliance with the "HIPAA Security Rule" as published on February 20, 2003 by the United States Department of Health and Human Services (HHS), and amended, including the final Security Standards under the Health Insurance Portability and Accountability Act of 1996 and the HITECH Act (Health Information Technology for Economic and Clinical Health Act) of the 2009. The Electronic Media contemplated by the HIPAA Security Rule includes the following:

(a) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(b) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission. In order to send and receive Protected Health Information ("PHI" as defined in the Plan Document) necessary for plan administration by Electronic Media, the Employer will implement reasonable and appropriate safeguards for electronic PHI created, received, maintained or transmitted to or by the Employer on behalf of the group health plan; ensure that electronic "firewalls" are in place to secure the electronic PHI; ensure that all agents and subcontractors with access to electronic PHI comply with the security requirements; Report to the group health plan any security incident of which it becomes aware.

Article V: Eligibility and Participation

5.01 **Eligibility Requirements.** Each Employee who enrolls in a Qualified Benefits Plan must be eligible to participate in this plan to receive the tax advantages made available under this plan. The eligibility requirements for this plan are set forth in the Enrollment Materials.

5.02 **Re-employment of Former Employees.** A Participant whose employment terminates and is subsequently re-employed within 30 days of his/her separation of service and within the same Plan Year will immediately rejoin the plan with the same benefit elections. Should the Participant return within 30 days of his/her separation of service during the following Plan Year, the Participant will be allowed to change elections through the plan enrollment process. A Participant whose employment terminates and who is subsequently re-employed with more than 30 days separation of service will need to re-satisfy plan eligibility requirements to rejoin the plan. Any unused reimbursement benefits account balance prior to the initial separation of service date will be forfeited.

5.03 **Termination of Participation.** A Participant will automatically cease to be a Participant on the earliest of the

following dates:

(a) the date on which this plan or any Qualified Benefits Plan is terminated by the Employer;
(b) the end of the Plan Year, unless the Participant enrolls in a Qualified Benefits Plan for the next Plan Year;
(c) the date on which the Participant fails to pay any required premium (including payment by salary reduction);
(d) when the Participant's employment is terminated the plan will terminate on the day of the termination or the day using the rule stated in the employer's enrollment materials or SPD.

5.04 **Family Medical Leave Act.** The Family & Medical Leave Act of 1993 (29 U.S.C. 2611) as amended, is referred to as FMLA. FMLA Leave will not be available to Employees for Plan Years in which the Employer has fewer than 50 Employees as counted in that Act. For Plan Years in which the Employer has 50 or more Employees, the Employer is required to make FMLA Leave available to Eligible Employees under circumstances that are prescribed by applicable federal law, including a period in which an Employee is off due to the FMLA shall be treated in accordance with the rules for a layoff or a leave of absence and provided to the extent required by the FMLA (e.g., the employer will continue to pay its share of the contribution to the extent the Participant opts to continue coverage). If the Employer is subject to the FMLA, a Participant may revoke or continue an election through the plan upon commencement of the FMLA Leave, whether such leave is paid or unpaid. This provision applies in addition to any other right to revoke and reelect benefits under the plan. Upon return from FMLA Leave, a Participant may be reinstated to all pre-leave elections.

5.05 **Uniformed Services Employment & Re-employment Rights Act (USERRA).** The Employer shall permit Participants to continue benefits elections as required under the Uniformed Services Employment & Reemployment Rights Act and shall provide such reinstatement rights as required by such law.

5.06 **Layoff, Leave of Absences, and Sabbaticals.** Continuation under the plan may occur in one of the following ways:

(a) In the case of a planned layoff, an Employee may be able to pre-fund a Qualified Benefits Plan through the end of the planned leave or the end of the Plan Year.
(b) During the period which the Employee is off and receiving a salary, the pre-tax deductions may continue. If the Employee is not receiving a salary, he/she may continue to fund his/her election with after-tax dollars while on leave. (Payment schedule to be agreed upon between the Employer and Employee prior to the commencement of the leave.)

Article VI: Elections

6.01 **Election Maximum Amounts.** The maximum election amounts for each Qualified Benefit Plan will be included in the Enrollment Materials and the literature available for each Qualified Benefits Plan.

6.02 **Failure to Elect.** A Participant failing to complete the enrollment process on or before the specified due date for the Plan Year, or a midyear enrollee during the Plan Year, shall be deemed to have elected to receive Compensation in cash.

6.03 **Effective Periods for Elections.** The election must be made by each Participant prior to the commencement of each Plan Year and shall be irrevocable for the Plan Year except as provided for in a Change in Status Event that would allow an election change.

6.04 **Non-Discrimination.** The plan is not intended to discriminate in favor of highly compensated individuals or key Employees as to eligibility to participate or contributions and benefits as required by the Code. The Employer may exclude or limit certain highly compensated individuals from participation in the plan, in the Employer's judgment, such actions serve to assure that the plan does not violate applicable non-discrimination rules. The Employer can make necessary adjustments to Employee contributions during the Plan Year to assure that the plan passes the required discrimination tests.

Article VII: Contributions

7.01 **Employer Contributions.** The Employer will contribute out of its general assets the amounts necessary to meet its obligations under the plan. The Employer may provide additional contributions in the way of cash or spending credits that can be used for any Qualified Benefits Plan or used in a limited manner as defined by the Employer. The Enrollment Materials will include the amount of any Employer contribution, the rules defining how the Employer contributions can be used by the Participants, and any limitations on the use of Employer contributions. Employer contributions will continue to be provided while on approved FMLA Leave

to the same extent provided to an Employee actively at work.

7.02 **Employee Salary Reductions.** The participant shall agree to reduce his/her Compensation from the Employer by such amounts as are necessary to provide for those Qualified Benefits Plans which the Participant has elected. No Participant shall have, by virtue of the plan, any interest in any specific asset or assets of the Employer. A Participant has only an unsecured contractual right to receive the benefits defined and limited by the Qualified Benefits Plans.

7.03 **Administrative Fees.** The Employer may charge the Employee reasonable cafeteria plan administrative fees.

7.04 **SIMPLE Section 125 Cafeteria Plan**. If the Employer intends to offer a SIMPLE Plan, as set forth in Code Section 125(j), under the Employer's Cafeteria Plan, then the Employer contributions are limited as follows;

a) Uniform Percentage Contribution Requirements: Employer must contribute to provide Qualified Benefits on behalf of each Qualified Employee, regardless of whether an Employee makes a salary contribution of their own. The Uniform Percentage Contribution method requires the Employer to contribute a uniform percentage (of at least two percent) of an Eligible Employee's compensation for the Plan Year.

b) Matching Contribution Requirements: Employer must contribute to provide Qualified Benefits on behalf of each Qualified Employee, regardless of whether an Employee makes a salary contribution of their own. The Matching Contribution method requires the Employer to make an annual contribution in an amount equal to the lesser of the following 2 options (select the lesser option): (1) 6% of each

Employee's Plan Year compensation, or (2) 2x the amount of salary reduction contributions from each Qualified Employee.

Article VIII: Account Plans

8.01 **Account Plan Availability.** The Employer will notify Accountholder in the Enrollment Materials if Account Plans are offered, and if included for the Plan Year the following terms apply.

8.02 **Forfeiture (Use-it-or-lose-it Rule).** An Accountholder forfeits any amount of his/her annual election that exceeds the reimbursement during any Plan Year. An Accountholder who terminates coverage during the Plan Year has a runout period in which to submit eligible claims. An Accountholder who is covered through the end of the Plan Year will have a runout period in which to submit eligible claims. The duration of these run out (the number of run out days will be provided in the Summary Plan Description) provided by the Employer. Upon such forfeiture, An Accountholder's accrual will be reduced to zero. Forfeited funds can be retained by the Employer, or at the discretion of the Employer, forfeitures of benefits under the plan can be reallocated to Accountholders in any reasonable manner that has no relation to prior claims history. Forfeitures of benefits also may be applied towards the cost of administering the plan. Forfeitures of benefits will become the sole property of the Employer.

8.03 **Accountholder Certification and Debit Card Use.** The Plan requires the Accountholder to certify that each expense submitted for reimbursement has actually been incurred and has not previously been reimbursed (i.e., there is no "double-dipping"), and reimbursement will not be sought from any other source, such as another health plan for medical tax advantaged account services. The Plan requires the Accountholder to certify that upon enrollment in a BASIC Subscription Service that includes the use of a BASIC Debit Card, for the immediate service year and any service year thereafter, that the card will only be used for legitimate eligible expenses, limited to persons eligible for reimbursement. This Certification is printed on the back of the BASIC Debit Card and reaffirmed each time the BASIC Debit Card is used. The BASIC Debit Card will be shut off and should not be used after the Accountholder's termination of employment, except for spending down MyCash that has been accumulated.

8.04 **Death of Accountholder**. In the event of the death of the Accountholder prior to the payment of any claims, payment will be made in the following priority:

a) Executor of the Estate of the deceased Accountholder,
b) Spouse, or,
c) Family member held responsible for payment of deceased's medical bills.

8.05 **Amounts Paid in Error**. Upon any benefits payment made in error, an Accountholder will be required to repay the Plan. The Employer may take reasonable steps to recoup such an amount, including reducing the amount of future benefits reimbursements by the amount paid in error.

8.06 **Grace Period.** The Summary Plan Description will indicate whether there is a Grace Period for any Account Plan. The Grace Period extends two - and one-half months after the last day of your Plan Year. The last day of the Grace Period is the fifteenth day of the third month following the end of the Plan Year. Services that are rendered after the last day of this Grace Period will not be considered for reimbursement under the prior Plan Year. An Accountholder must be enrolled through the end of the last day of the Plan Year in order for this Grace Period to apply. Services that qualify for reimbursement and are rendered during the Grace Period will be reimbursed using any balance in the prior Plan Year annual election first, and then reimbursed from any new Plan Year annual election. If an Accountholder terminates coverage for any reason prior to the end of the last day of the Plan Year, then the Accountholder may not submit any claims for services that were rendered after your date of termination.

8.07 **Healthcare Flexible Spending Account (FSA). (CHECK YOUR ENROLLMENT MATERIALS TO DETERMINE IF THIS ACCOUNT PLAN IS OFFERED)** This plan is intended to provide reimbursement for certain medical expenses incurred and not otherwise covered by insurance or by the Employer. The Employer intends that the plan qualify as an accident and health plan under Section 105 and 106 of the Internal Revenue Code, and that the nontaxable benefits provided under the plan be eligible for exclusion from an Accountholder's incomes under Section 105(b) of the Code. The Healthcare FSA is an Employer Sponsored Welfare Plan as defined by ERISA (Employee Retirement Income Security Act of 1974) and is subject to ERISA. The Employer will provide a Summary Plan Description within 90 days of enrollment or on request. The Summary Plan Description will identify the Plan Administrator for this plan.

Qualified Expenses. All healthcare expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, (b) incurred by an Accountholder, Accountholder's spouse, or dependent, (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit plan or account. Services and supplies must be for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Services and supplies that are beneficial" to an individual's general health" are not covered unless they are determined by a physician to be necessary to treat or alleviate a specific physical or mental illness. Amounts paid for menstrual care products shall be treated as paid for medical care. Over-the-counter (OTC) products no longer require a prescription and can be reimbursed under this Plan.

Benefits. Benefits are provided from the Employer's general assets. There are no segregated funds established for this plan. The amount of an Accountholder's annual election is available on each day of the Plan Year in which the Employee is an Accountholder. An Accountholder is entitled to benefits under the plan for a Plan Year in an amount that does not exceed an Accountholder's annual election, and Employer contributions, if any. The amount of an Accountholder's annual election will be uniformly available during the Plan Year.

Claims. Each claim will be substantiated by the submission of a third-party statement that shows that the claim is for a Qualified Benefits Expense, or by automated means that comply with guidelines established under IRS Rev. Rul. 2003-43. If claims are submitted electronically, an Accountholder will sign a certification upon Enrollment or acceptance of an electronic card that claims submitted under the card have not been reimbursed by any other insurance or self-insured plan, and that an Accountholder is not seeking reimbursement under any other insured or self-insured plan. Services purchased under a prefunded debit card can be automatically substantiated as allowed under IRS Notice 2006-69, including claims that are automatically substantiated using the Inventory Information Approval System (IIAS), amounts that are a multiple of a health plan copayment (up to five multiple copayments).

Limited Coverage (Spouse covered under an HSA). Section 1201 of the Medicare Prescription Drug, Improvement & Modernization Act of 2003, added Section 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts (HSAs) for taxable years beginning on or after December 31, 2003. In order to allow an Employee's Spouse to contribute to an HSA Account, an Employee is required to submit a written request to the Benefits Coordinator requesting "single" or "Parent and Child(ren)" enrollment in this Healthcare FSA. Qualified Expenses are limited to covered services or supplies provided to the Employee and Dependents that are not covered under the Spouse's HSA. No claims for family members covered under the HSA can be submitted under this plan.

Carryover. The Allowed Carryover Maximum, if any, will be communicated on the first page of the Summary Plan Description provided to each Eligible Employee at open enrollment or when a new or existing Employee becomes eligible for enrollment in the plan. The Carryover Maximum will be the lessor of the amount communicated in the Enrollment Communications or maximum allowed. The Allowed Carryover will be the lesser

of the Allowed Carryover Maximum or the unused benefit balance at the end of the Runout Period. A Runout Period immediately follows the end of a Plan Year during which an Accountholder may request reimbursement of expenses incurred for qualified benefits during the Plan Year. The duration of any Runout Periods will be detailed in the Summary Plan Description provided by the Employer. The amount carried over has no effect on the ability to elect the maximum salary reduction allowed under the plan for the new Plan Year. If an Accountholder elects the maximum salary reduction allowed under the plan, then the amount carried over will be in addition to that election.

Military Cash Out Option. An Accountholder in the plan will receive a Qualified Reservist Distribution upon written request provided to the Employer. A Qualified Reservist Distribution means a distribution to an Accountholder of all or a portion of the balance in the employee's account under the plan, if:

(a) an Accountholder was (by reason of being a member of a reserve component (as defined in section 101 of title 37, United State Code)) ordered or called to active duty for a period of 180 days or more, or for an indefinite period; and,

(b) the distribution is requested and made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the plan for the Plan Year in which an Accountholder received the order or call.

The balance that can be distributed is limited to the amount of an Accountholder's actual payroll deductions made as of the date of the request, less any amount that has already been disbursed for valid claims submitted.

COBRA Continuation Coverage. The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as amended from time to time, does not apply to any group health plan of the Employer for any calendar year if all employers maintaining the plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. An Accountholder eligible for COBRA continuation coverage under this plan, shall be allowed to continue to participate in the plan until the end of the Plan Year in which the qualifying event occurred, as long as such an Accountholder complies with the provisions set out in COBRA. An Accountholder is eligible for COBRA coverage only when the cost to continue to the end of the Plan Year exceeds the remaining benefit. The Employer shall adopt rules relating to continuation coverage, as provided under Section 4980B of the Internal Revenue Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

8.08 Limited Purpose Healthcare Flexible Spending Account. (CHECK YOUR ENROLLMENT MATERIALS TO DET DETERMINE IF THIS ACCOUNT PLAN IS OFFERED) This is a Healthcare Flexible Spending Account intended to accommodate persons who are making contributions to a Health Savings Account (HSA) and enrolled in a high deductible health plan ("HDHP") option. Any Employee who contributes to an HSA and elects to participate in this Healthcare FSA will automatically be placed in a Limited Purpose Healthcare FSA. A Limited Purpose Healthcare FSA provides reimbursement only for Qualified Expenses not otherwise covered by insurance or by the Employer that are for dental and vision services, and if designated as a Limited Purpose Post-Deductible Healthcare FSA, may also include qualified medical services provided after the HDHP statutory annual deductible has been satisfied.

8.09 Limited Purpose Post-Deductible Healthcare FSA. **(CHECK YOUR ENROLLMENT MATERIALS TO DETERMINE IF THIS ACCOUNT PLAN IS OFFERED)** A Qualified Expense under a Limited Purpose Post-Deductible Healthcare FSA is the same as a Qualified Expense under the Limited Purpose Healthcare FSA. With the Limited Purpose Post-Deductible Healthcare FSA, after the statutory annual HDHP deductible has been satisfied, Qualified Expenses that are not covered by the HDHP can be submitted and reimbursed. An Explanation of Benefits ("EOB") from the insurance carrier that administers the HDHP is required to be submitted. The EOB needs to show the statutory HDHP deductible has been satisfied and the portion of the expense that has been submitted for reimbursement under this plan was not applied to the HDHP deductible.

8.10 Non-Employer Sponsored Premium Account. **(CHECK YOUR ENROLLMENT MATERIALS TO DETERMINE IF THIS ACCOUNT PLAN IS OFFERED)** This plan is intended to comply with Section 125 of the Internal Revenue Code. The Healthcare Premium (NESP) Reimbursement Account is a tax advantaged plan established with the intent of providing tax free reimbursement for the premium paid by an Employee for an individual insurance, providing health and accident benefits as defined under Sections 105 and 106 of the Code. The individual insurance plan is owned by the Employee. This can include a plan provided through Employee owned insurance policy(ies) issued by an insurance company, or a contract(s) with a health maintenance organization or point of service organization. Coverage offered through the Marketplace, (a state or federal plan under the Affordable Care Act), does not qualify. The following individual plans can be covered under the Healthcare Premium (NESP) Reimbursement Account.

a) Health insurance or HMO coverage for health expenses

b) Dental insurance

c) Eye care insurance
d) Medicare premium
e) Medigap or Medicare Supplemental premium
f) Tricare premium
g) Accidental death and dismemberment insurance
h) Long-term or short-term disability insurance

The Healthcare Premium (NESP) Reimbursement Account is not subject to the Employee Retirement Income Security Act of 1974 (ERISA). The individual plans purchased by the Employees are not Employer-Sponsored Welfare Plans as defined by ERISA, and as such are not subject to ERISA.

8.11 Dependent Care Flexible Spending Account (FSA). (CHECK YOUR ENROLLMENT MATERIALS TO DETERMINE IF THIS ACCOUNT PLAN IS OFFERED) This plan is intended to provide reimbursement for certain Dependent Care Expenses incurred by an Accountholder. The Employer intends that the plan qualify as a dependent care assistance plan under Section 129(d) of the Internal Revenue Code, and that the nontaxable benefits provided under the plan be eligible for exclusion from an Accountholder's income under Section 129 of the Code. This plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Maximum Contribution. An Accountholder can defer the lesser of $5,000, their earned income, or the Spouse's earned income, per Plan Year. If a Spouse is disabled or a full-time student with no income, then the Spouse is deemed to have a monthly income of $250, if one dependent, $500 if two or more dependents. A married Accountholder who files a separate tax return is limited to $2,500 per year. Contributions to the plan are made and limited in accordance with an Accountholder's annual election.

Maximum Benefit. An Accountholder can never withdraw more funds than actually contributed on the date a claim is submitted. If an Accountholder fails to use his/her entire election at the end of the Plan Year or upon other termination of the plan, the unused election cannot be cashed out and becomes the property of the Employer.

Dependent Care Expenses. Expenses incurred by an Accountholder for the care of a Qualified Person or for related household services which would be considered employment-related expenses under Section 21(b)(2) of the Internal Revenue Code.

Qualifying Person. All child and Dependent Care Expenses must be for the care of one or more Qualified Persons. A Qualifying Person is defined as the following:

a) A child who is claimed as an Accountholder's Dependent and who was under the age of 13 when the care was provided;
b) An Accountholder' Spouse who was physically or mentally unable to care for himself/herself and lived with an Accountholder for more than half of the year;
c) A person who was physically or mentally unable to care for himself or herself and lived with an Accountholder for more than half of the year, and either of the following:
    1) Was an Accountholder's Dependent; or
    2) Would have been an Accountholder's Dependent without the occurrence of one of the following:
    3) He or she received gross income equal to or in excess of the exemption amount for Dependents under Internal Revenue Code § 151(d);
    4) He or she filed a joint tax return;
    5) An Accountholder or an Accountholder's Spouse if filing jointly, could be claimed as a Dependent on someone else's federal tax return.

Child of divorced or separated parents. Even if an Accountholder cannot claim a child as a Dependent, he or she is treated as a Qualifying Person if one of the following applies.

a) The child was under the age of 13 or was physically or mentally unable to care for himself/herself; or
b) An Accountholder was the child's custodial parent (the parent with whom the child lived for the greater part of the calendar year), and the non-custodial parent is entitled to claim the child as a Dependent under the special rules for a child of divorced or separated parents. If this applies, the non-custodial parent cannot treat the child as a Qualifying Person.

Benefits and claims. Benefits are provided only for the reimbursement of a Qualified Person's Dependent Care Expenses that are incurred during the Plan year and during the period in which the Employee was an Accountholder. Benefits are limited to the amount that has actually been withheld from an Accountholder's Compensation on the date the claim is processed. Reimbursement will be made under the plan only on the basis of Dependent Care. To make the determination that a Dependent Care Expense subject to reimbursement has been incurred, proper evidence of any or all of the following may be required:

a) The name of the Qualified Person for whom the expenses have been incurred;

b) The nature of the services incurred;
c) The date the services were incurred;
d) The amount of the requested reimbursement; and,
e) That the expenses have not been otherwise paid through a program offered by the Employer or any other employer or reimbursed from any other source.

Appendix D: Notice of HIPAA Privacy Practices

Purpose: Privacy notices must be given to individuals covered by the plan. A single notice to a covered employee is effective for all covered dependents. Notices must be provided upon enrollment, and within 60 days of a material change to the notice. Plans must notify participants every 3 years that a privacy notice is available. Consistent with other template forms, this Notice assumes the plan does not, with respect to protected health information: (1) engage in fundraising; (2) engage in marketing, where the plan receives financial remuneration for such marketing; (3) sell protected health information; (4) use genetic information for underwriting purposes; or (5) engage in research. If these assumptions are not correct this Notice should be changed.

Pathways Home Health & Hospice Group Welfare Plan
PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Our Privacy Practices

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally-approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints

regarding or additional information about our privacy practices.

Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Contact Office.

Contact Office: Pathways Home Health and Hospice

Telephone: (888) 978-1306

Fax: N/A

E-mail: nancy.ruma@commonspirit.org

Address: 585 N. Mary Ave, Sunnyvale CA, 94085

Health Plans Covered by this Notice

This notice applies to the privacy practices of the health plans listed below. They may share with each other your medical information, and the medical information of others they service, for the health care operations of their joint activities.

Healthcare Flexible Spending Account (FSA)

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **July 1, 2025**, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of

the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes we hold only with your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

Your Employer: We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical

information contained in the summary health information as yours. We are expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

We may disclose your medical information and the medical information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your medical information. Please see your group health plan document for a full explanation of those limitations.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Your Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request in writing to our Contact Office.

We may charge you reasonable, cost-based fees (including labor costs) for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Contact Office for information about our fees.

Your medical information may be maintained electronically. If so, you can request an electronic copy of your medical information. If you do, we will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as we mutually agree upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to

the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

Amendment. You have the right to request that we amend your medical information. You should submit your request in writing to the contact at the end of this notice.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and

2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request in writing to the contact at the end of this notice.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Contact Office to obtain this notice in written form.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may complain to our Contact Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Appendix E: Authorized Representatives

Appointment of Authorized Representative

I, _____

[name of claimant]

hereby appoint_____ to act on my behalf

[name of Authorized Representative]

or on behalf of_____

[name of patient: plan participant or beneficiary]

in connection with any claim for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to receive any and all information that is provided to me, and to act for me and for my covered spouse or dependent, if named above as the patient, in providing any information to the Plan that relates to any claim for coverage or benefits under the Plan.

This form does not constitute an assignment of rights for direct payment.

□ Distribute to me and to my Authorized Representative: All information and notifications should be distributed to me and to my Authorized Representative.

_____ _____

Claimant's signature Date

Accepted:_____ _____

Authorized Representative's signature Date

Witness:_____ _____

Witness signature Date