SUMMARY PLAN DESCRIPTION
FOR THE
OUTPATIENT DIALYSIS HEALTH REIMBURSEMENT ARRANGEMENT PLAN
OF AMY'S KITCHEN, INC.

January 1, 2023

Benefits Administered by Specialty Care Management

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INTRODUCTION

Amy's Kitchen, Inc. ("Employer") is pleased to provide you with this summary plan description ("SPD") for the Employer's Outpatient Dialysis Health Reimbursement Arrangement Plan (the "Plan"). This SPD is effective as of January 1, 2023. As you read it, you should keep in mind that it is merely a summary, and not a complete statement of all of the Plan terms. Each individual covered under the Plan will receive an Outpatient Dialysis identification card stating that they are eligible to receive Outpatient Dialysis Services. On the back of this card are telephone numbers to call in case of questions or problems. You can also get additional information and examine a copy of the Plan by contacting the Plan Administrator at its address shown below. You should keep a copy of this SPD in your permanent records.

IMPORTANT WORDS AND PHRASES USED IN THIS SPD

To understand this SPD you need to know the meanings of the following words and phrases:

A. **Benefit Administrator** — Specialty Care Management, LLC ("SCM").

B. **Covered Person** — an Eligible Employee or Dependent who requires Outpatient Dialysis Services.

C. **Dependent** — your dependent as defined in the Group Health Plan and who is covered under such Group Health Plan.

D. **Effective Date of the Plan** — November 1, 2022, the date the Plan became effective.

E. **Eligible Employee** — each Employee who both is enrolled in the Group Health Plan and requires Outpatient Dialysis Services.

F. **Eligible Medical Expenses**— the cost of outpatient dialysis procedures (used for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis) as well as the cost of diagnostic testing, laboratory tests, equipment and supplies used in the treatment of acute renal failure and/or chronic renal insufficiency and other diagnoses related to renal failure ("Outpatient Dialysis Services"). This also includes injectable and intravenous medications including but not limited to Heparin, Epogen, Procrit and other medications administered directly before, during or after an outpatient dialysis procedure. Outpatient Dialysis Services must be medically necessary, and the cost of such Services will be calculated in accordance with the terms of the Plan.

G. **Employee** — any individual in the employment of the Employer if the relationship between them and the Employer is the legal relationship of employer and employee.

H. **Employer** – Amy's Kitchen, Inc.

I. **ERISA** — the Employee Retirement Income Security Act of 1974.

J. **Group Health Plan** – the Amy's Kitchen, Inc. Employee Benefit Health Plan.

K. **Maximum Annual Credit Amount" --** $500,000 for a Plan Year. The Maximum Annual Credit Amount will be prorated for any short Plan Year.

L. **Medical Reimbursement Account** — the account established and maintained for a Participant by the Employer.

M. **Monthly Credit Amount** — the monthly amount credited to a Participant's medical reimbursement account by the Employer. The Monthly Credit Amount will be in an amount sufficient to reimburse the cost of eligible medical expenses for the month, as calculated in accordance with the terms of the Plan. The Monthly Credit Amount shall not exceed the amount calculated under the "Benefits" section of this SPD. The Monthly Credit Amount shall be credited to the Participant's medical reimbursement account as of the first day of each month.

N. **Participant** — an Employee who has satisfied the Plan's eligibility requirements.

O. **Plan Administrator** — the Employer.

P. **Plan Year** — the 12-month period that ends on December 31 of each year.

Q. **Usual and Customary** — eligible medical expenses, which are identified by the Plan Administrator, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates as such information is made publicly available. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) for the specific service or supply furnished to a Participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary. Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios as such information is made publicly available, average wholesale price for prescriptions and/or manufacturer's retail pricing for supplies and devices.

IMPORTANT MISCELLANEOUS FACTS

A. The name of the Plan and the Plan Number are:

NAME	PLAN NUMBER
Outpatient Dialysis Health Reimbursement Arrangement Plan of Amy's Kitchen, Inc.	502

B. The name, address, and employer identification number (EIN) of the Employer are:

NAME and ADDRESS of EMPLOYER	EIN
Amy's Kitchen, Inc. 1650 Corporate Circle Ste. 100 Petaluma, CA 94954	68-0154899

C. The name, business address, and business telephone number of the Plan Administrator and Named Fiduciary are:

NAME and ADDRESS	PHONE NUMBER
Amy's Kitchen, Inc. 1650 Corporate Circle Ste. 100 Petaluma, CA 94954	(707) 781-7796

D. The name, business address, and business telephone number of the Benefit Administrator are:

NAME and ADDRESS	PHONE NUMBER
Specialty Care Management P.O. Box 732 Lahaska, PA 18931	(267) 544-0566

E. The Plan Administrator, named in paragraph C above, is the agent for service of legal process on the Plan. Legal process may be served at the address specified in paragraph C.

F. The Plan keeps its records and is administered on a Plan Year basis.

TYPE OF PLAN

As its name implies, the Plan is a health reimbursement arrangement plan. Within the limits described below, the Employer will reimburse Participants for amounts incurred by such Participants or such Participant's Dependents for appropriate Eligible Medical Expenses that are not reimbursed by another medical plan (whether sponsored by the Employer or otherwise). Please ask the Benefit Administrator if you have a question as to whether a particular Eligible Medical Expense is reimbursable.

ADMINISTRATION

The Plan is administered by the Employer through the Plan Administrator. In general, the Plan Administrator is responsible for the operation and administration of the Plan. For example, the Plan sets forth requirements for determining who is eligible to participate in the Plan and the Plan Administrator makes sure these requirements are met.

ELIGIBILITY

All Employees who are enrolled in the Group Health Plan and who require Outpatient Dialysis Services are eligible to participate in the Plan. Dependents who are also enrolled in the Group Health Plan are eligible to participate in the Plan if they require Outpatient Dialysis Services.

An Employee or Dependent becomes a Covered Person as of the first day of the first month in which they both (i) are covered under the Group Health Plan and (ii) undergo any Outpatient Dialysis Services.

A Participant who is no longer covered under the Group Health Plan will cease to be a Participant on the date their coverage under the Group Health Plan ceased. If such Participant subsequently becomes covered under the Group Health Plan, they will reenter the Plan as a Participant immediately if they require Outpatient Dialysis Services.

BENEFITS

The Plan provides reimbursement for Eligible Medical Expenses incurred by Participants and Dependents. In no event, however, will the Plan Administrator reimburse any Participant for Eligible Medical Expenses paid for by insurance or otherwise, nor will any Participant be reimbursed for expenses incurred before becoming a Participant or after participation in the Plan has ended.

The Employer will establish and maintain on its books a Medical Reimbursement Account with respect to each Participant. The Monthly Credit Amount shall be credited to the Participant's Medical Reimbursement Account as of the first day of each month. All amounts credited to each such Medical Reimbursement Account shall be the property of the Employer until paid out under the terms of the Plan. In no event shall the total amount credited to your Medical Reimbursement Account for any Plan Year exceed the Maximum Annual Credit Amount.

The cost of Eligible Medical Expenses will be calculated at the Usual and Customary amount which, at the Plan Administrator's sole discretion and if applicable, will not exceed the Maximum Allowable Charge applicable to the treatment, supplies, and/or services, which typically is 125% of the current Medicare allowable fee for the appropriate area as such information is made publicly available. The Plan does not utilize any network. In some circumstances, you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (known as balance billing).

All Covered Persons requiring outpatient dialysis are subject to cost containment review, claim audit and/or review, negotiation and/or other related administrative services, which the Plan Administrator may elect to apply in the exercise of the Plan Administrator's discretion.

The Plan will reimburse each Participant for the cost of Eligible Medical Expenses incurred during the Plan Year by such Participant and such Participant's Dependents. An Eligible Medical Expense is incurred at the time the care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the care or service. In no event shall benefits under the Plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for eligible medical expenses.

All claims for Eligible Medical Expenses must be submitted no later than 12 months from the date of the Outpatient Dialysis Services.

An Eligible Medical Expense is considered incurred at the time the care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the care or service.

The Plan is intended to meet certain requirements of existing federal tax laws, under which the reimbursement benefits that you receive under the Plan are not taxable to you. The Employer cannot guarantee the tax treatment to any Participant, since individual circumstances may differ. If there is any doubt, you should contact your own tax advisor.

A Covered Person diagnosed with a condition requiring outpatient dialysis may be able to enroll in Medicare. The Plan will not enroll the Covered Person in Medicare; it is the Covered Person's decision and responsibility to enroll in Medicare, if applicable.

DISQUALIFICATION AND REDUCTION, LOSS, FORFEITURE, OR DENIAL OF BENEFITS

There are a few circumstances under which Participants can lose the reimbursement benefits provided under the Plan. These are listed below and should be read carefully:

A. The Employer can stop or change the Plan (e.g., change the eligibility requirements, change the reimbursement amount) at any time. However, if this happens, it will not affect the right, if any, of a Participant to receive reimbursement for Eligible Medical Expenses incurred before the Plan ends, or the change becomes effective.

B. If the Employer does not continue to have financial success, it may not be able to make reimbursements.

C. An Employee may no longer meet the eligibility requirements because of a change in their employment status with the Employer or failure to be enrolled in the Group Health Plan.

D. If a Participant does not incur Eligible Medical Expenses equal to or in excess of the maximum amount reimbursable for a Plan Year, the difference is forfeited. It cannot be used in a later Plan Year (i.e., unused amounts do not roll over from year to year).

CONTRIBUTIONS AND FUNDING

The Employer will pay all costs of the Plan out of its general assets. No money is set-aside in advance for this purpose.

CLAIMS PROCEDURE

Type of Claims and Definitions.

Pre-Determination: A Pre-Determination is a determination of benefits by the Benefit Administrator, on behalf of the Plan, prior to Outpatient Dialysis Services being provided. This Plan requires Pre-Determination for visits to an outpatient dialysis facility. A Pre-Determination serves the purpose of providing prior notification to the Benefit Administrator of the visit for Outpatient Dialysis Services, and it informs a Covered Person of whether, and under which circumstances, an Outpatient Dialysis Service is generally a covered benefit under the Plan. In order to obtain a Pre-Determination, the Covered Person should call the Benefit Administrator at (267) 544-0566. A Pre-Determination is not a claim and, therefore, cannot be appealed. A Pre-Determination that Outpatient Dialysis Services may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

Pre-Service Claim (needing prior authorization): This is a claim for a benefit where the Covered Person is required to get prior authorization from this Plan before obtaining the service. This Plan requires Pre-Determination for Outpatient Dialysis Services, but it does not require prior authorization. In the case that the Plan may grant prior authorization, it does not guarantee that the Plan will ultimately pay the claim.

Post-Service Claim: This is a claim that involves payment for the cost of health care that has already been provided.

Concurrent Care Claim: This is a claim that means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

Personal Representative. Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. A minor dependent must have the signature of a parent or legal guardian in order to appoint a third party as a Personal Representative. If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the

following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant their Personal Representative access to their Protected Health Information. The Covered Person should contact the Benefit Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

Submission of Claims for Eligible Medical Expenses.

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the Outpatient Dialysis Services claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting Outpatient Dialysis Services claims is on the back of the Outpatient Dialysis identification card.

A Covered Person who receives Outpatient Dialysis Services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the Outpatient Dialysis Services claim to the Plan for reimbursement. The Plan will reimburse the Covered Person for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of Outpatient Dialysis Services if the paid date is not known.

A complete Outpatient Dialysis Services claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, Social Security number, address, and relationship to the Covered Person
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto Accident, or another Accident (if applicable)
- Assignment of benefits (if applicable)

Timely Filing.

Covered Persons are responsible for ensuring that complete Outpatient Dialysis Services claims are submitted to SCM as soon as possible after Outpatient Dialysis Services are received, but no later than 12 months from the date of the Outpatient Dialysis Services. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to 3 years from the date of Outpatient Dialysis Service. A Veteran's Administration Hospital has 6 years from the date of the Outpatient Dialysis Service to submit the Outpatient Dialysis Services claim. A complete claim means that the Plan has all of the information that is necessary in order to process the Outpatient Dialysis Services claim. Outpatient Dialysis Services claims received after the timely filing period will not be allowed.

Incorrectly Filed Claims (Applies to Pre-Service Claims only).

If a Covered Person or Personal Representative attempts to, but does not properly follow the Plan's procedures for requesting prior authorization, SCM will notify the person and explain the proper procedures within 5 calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

How Health Benefits Are Calculated.

When SCM receives a claim for an Outpatient Dialysis Service that has been provided to a Covered Person, it will determine if the Outpatient Dialysis Service is an Eligible Medical Expense under the Plan. If the Outpatient Dialysis Service is not an Eligible Medical Expense, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the Outpatient Dialysis Service is as Eligible Medical Expense, SCM will establish the allowable payment amount for that Outpatient Dialysis Service, in accordance with the terms of the Plan as explained in the "Benefits" section of this SPD.

Notification of Benefit Determination.

If an Outpatient Dialysis Services claim is submitted by a Covered Person or a provider on behalf of a Covered Person, and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility. The provider will receive a similar form for each Outpatient Dialysis Services claim that is submitted.

Timelines for Initial Benefit Determination.

SCM will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

Pre-Service Claim: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.

Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.

Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.

A claim is considered to be filed when the claim for benefits has been submitted to SCM for formal consideration under the terms of the Plan.

Circumstances Causing Loss or Denial of Benefits.

Outpatient Dialysis Services claims may be denied for any of the following reasons:

- Termination of employment.
- A Covered Person's loss of eligibility for coverage under the Plan.
- Charges are incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Termination of the Group Health Plan.
- The Covered Person or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under the Plan.
- Services are not considered medically necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums, if required.
- The Covered Person is responsible for charges due to deductible, Plan participation obligations or penalties, where applicable.
- Application of the Usual and Customary fee limits, the fee schedule or negotiated rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered experimental, investigational or unproven.
- Other reasons as stated elsewhere in the Plan.

Adverse Benefit Determination (Denied Claims).

Adverse Benefit Determination means a denial, reduction or termination of the benefits under the Plan, or a failure to provide or make payment, in whole or in part, for Eligible Medical Expenses. It also includes any such denial, reduction, termination, rescission of coverage with respect to the benefits under the Plan (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Participant to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on medical necessity or experimental, investigational, or unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

Appeals Procedure for Adverse Benefit Determinations.

If a Covered Person disagrees with the denial of an Outpatient Dialysis Services claim or a rescission of coverage determination, the Covered Person or their Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative. The Plan Administrator shall offer two levels of mandatory appeals as discussed below.

First Level of Appeal: This is a mandatory appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the Outpatient Dialysis Services claim was denied. The Plan will assume the Covered Person received the EOB form 7 days after the Plan mailed the EOB form.

- The Covered Person or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.

- The Covered Person may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.

- The Covered Person has the right to submit evidence related to their Outpatient Dialysis Services claim.

- The review will take into account all comments, documents, records and other information submitted that relates to the Outpatient Dialysis Services claim. This will include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the Outpatient Dialysis Services claim.

- If the Outpatient Dialysis Services claim denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the Outpatient Dialysis Services claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any Outpatient Dialysis Services claim determinations.

- After the Outpatient Dialysis Services claim has been reviewed, the Covered Person will receive written notification letting them know if the Outpatient Dialysis Services claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of their right to file suit under ERISA after they have completed all mandatory appeal levels described in the Plan.

Second Level of Appeal: This is a mandatory appeal level. The Covered Person is required to follow this internal procedure before taking outside legal action. A Covered Person is required to complete this mandatory second level appeal prior to submitting a request for independent External Review.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.

- The Covered Person or their Personal Representative must submit a written request for a second review within 60 calendar days of the decision related to the first level of

review. The Plan will assume that the Covered Person received the determination letter related to the first level of review 7 days after the Plan sent the determination letter.

- The Covered Person may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.

- The Covered Person has the right to submit evidence related to their Outpatient Dialysis Services claim.

- The second review will take into account all comments, documents, records and other information submitted that relates to the Outpatient Dialysis Services claim that either were not submitted previously or were not considered in the initial Outpatient Dialysis Services claim decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal and are not under the supervision of those individuals.

- If the Outpatient Dialysis Services claim denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the Outpatient Dialysis Services claim, the experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any Outpatient Dialysis Services claim determinations.

- After the Outpatient Dialysis Services claim has been reviewed, the Covered Person will receive written notification letting them know if the Outpatient Dialysis Services claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with an Outpatient Dialysis Services claim that is being appealed, the Plan will automatically provide the relevant information. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of their right to file suit under 502 (a) ERISA after they have completed all mandatory appeal levels described in the Plan.

A Covered Person should send their appeal within the prescribed time period as stated above to the following addresses:

<u>Send Pre-Service Claim Medical appeals to</u>:

Specialty Care Management
P.O. Box 732
Lahaska, PA 18931
(267) 544-0566

Send Post-Service Claim Medical appeals to:

Specialty Care Management
P.O. Box 732
Lahaska, PA 18931
(267) 544-0566

Time Periods for Making Decision on Appeals.

After reviewing an Outpatient Dialysis Services claim that has been appealed, the Plan will notify the Covered Person of its decision within the appropriate timeframes. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to the Covered Person free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is unable to provide the Covered Person with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow the Covered Person a reasonable opportunity to respond to the new or additional evidence.

Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.

Post-Service Claim: Within a reasonable period of time but no later than 30 calendar days after the Plan receives the request for review.

Concurrent Care Claims: As soon as possible, but no later than 72 hours after the Plan's receipt of request for appeal.

Right to External Review.

If, after exhausting the internal appeals, the Covered Person is not satisfied with the final determination, the Covered Person may choose to participate in the external review program. This program applies only if the adverse benefit determination involves:

- Clinical reasons;
- The exclusions for experimental, investigational, or unproven services;
- Determinations related to entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits); or
- Other requirements of applicable law including but not limited to compliance with the No Surprises Act.

This external review program offers an independent review process to review the denial of requested Outpatient Dialysis Services (other than a pre-determination of benefits) or the denial of payment for Outpatient Dialysis Services. The process is available at no charge to a Covered

Person after the Covered Person has exhausted the appeals process identified above and received a decision that is unfavorable, or if SCM or the Plan Sponsor fail to respond to the appeal within the timelines stated above.

A Covered Person may request an independent review of the Adverse Benefit Determination. Neither the Covered Person, SCM nor the Plan Sponsor will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If the Covered Person wishes to pursue an external review they should send a written request to the following address:

Specialty Care Management
P.O. Box 732
Lahaska, PA 18931
(267) 544-0566

The written request should include: (1) a specific request for an external review; (2) the Covered Person's name, address, and member ID number; (3) the designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. The Covered Person will be provided more information about the external review process at the time the request is received.

Any requests for an independent review must be made within 4 months of the date the Adverse Outpatient Dialysis Services Claim Determination is received. The Covered Person or an authorized designated representative may request an independent review by contacting the toll-free number on the Outpatient Dialysis identification card or by sending a written request to the address on the Outpatient Dialysis identification card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested Outpatient Dialysis Services are a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by SCM and has no material affiliation or interest with SCM or the Plan sponsor. SCM will choose the IRO based on a rotating list of approved IROs. In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of SCM's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by SCM and/or the Plan Sponsor in making a decision on the case; and
- All other information or evidence that the Covered Person or the Covered Person's Physician has already submitted to SCM or the Plan sponsor.

If there is any information or evidence that was not previously provided and that the Covered Person or the Covered Person's physician wishes to submit in support of the request, this information may be included with the request for an independent review, and SCM will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be

extended. The independent review process will be expedited if the criteria is met for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide the Covered Person and SCM and/or the Plan Sponsor with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide coverage for such Outpatient Dialysis Services in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide coverage for such Outpatient Dialysis Services.

The Covered Person may contact the Benefit Administrator at the number on the Outpatient Dialysis identification card for more information regarding external appeal rights and the independent review process.

Legal Actions Following Appeals.

After completing all mandatory appeal levels in the Plan, a Covered Person has the right to further appeal an Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). No lawsuit or legal action of any kind related to a benefit decision may be filed by a Covered Person in a court of law or in any other forum, unless it is commenced within one (1) year of the Plan's final decision on the claim or other request for benefits.

Physical Examination and Autopsy.

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

Right to Request Overpayments.

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under the Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan sponsor determines the payment to the Covered Person or any party is greater than the amount payable under the Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

Coordination of Benefits.

If any Covered Person is eligible for Medicare benefits because of End Stage Renal Disease, the coverage of Outpatient Dialysis Services under the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement (with respect to charges incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the coverage under the Plan will be determined in accordance with such law. In order for the Plan to coordinate with Medicare coverage, the Plan requires Covered Persons to follow the following steps:

- Notify the Benefit Administrator and send a copy of the Covered Person's Medicare card when enrolled in Medicare; and
- Notify the Benefit Administrator if or when Outpatient Dialysis Services begin to be received. If Medicare reimbursement rates are neither available nor applicable, rates will be set in accordance with this Plan's Usual and Customary provisions and other provisions.

MISCELLANEOUS INFORMATION

COBRA Continuation Coverage.

Under a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), you may have certain rights to continue benefits under the Plan for a period which is generally 18 months, but may be as long as 3 years. COBRA will apply only if the Employer employed 20 or more Employees on a typical business day during the preceding year.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of COBRA continuation coverage***

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

- ***Second qualifying event extension of 18-month period of continuation coverage***

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program ("CHIP") or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my Plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA

election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be directed to the Plan Administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Amy's Kitchen, Inc.
1650 Corporate Circle Ste. 100
Petaluma, CA 94954
(707) 781-7796

If you have any questions as to the applicability of COBRA or as to continuation coverage under the Plan in the event of termination of employment, divorce, or other change in status, please contact the Plan Administrator.

USERRA.

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") permits you to elect to continue participation in the Plan when you are absent from employment on account of being in "uniformed service." Your period of coverage will continue for the lesser of 18 months or until you fail to apply for reinstatement or to return to the employment of the Employer. The Plan Administrator will provide more information if you continue participation while absent on account of being in uniformed service.

Leave of absence

Coverage may continue for a limited time, but not to exceed eighteen (18) months. Coverage is contingent upon payment of any required contributions for Employees and/or Dependents required under the corresponding Group Health Plan, when the Employee is on authorized Employer Leave of Absence. For additional information about Amy's Kitchen, Inc.'s leave policy, please contact the Human Resources Department.

Family and Medical Leave Act.

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), their employer will continue coverage under the Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Employee has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal FMLA and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage and/or coverage under this Plan during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact your Human Resources or Personnel Office.

Qualified Medical Child Support Orders.

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a "qualified medical child support order." Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (1) creates or extends the rights of an "alternate recipient" to participate in a Group Health Plan, including the Plan, or (2) enforces certain laws relating to medical child support. An "alternate recipient" is any child of a Covered Person who is recognized by a medical child support order as having a right to enrollment under a Covered Person's Group Health Plan.

A medical child support order must satisfy certain specific conditions to be qualified. You will be notified by the Plan Administrator if it receives a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified.

Assignment of Benefits.

Your Plan permits you to assign your right to submit claims for payment to a provider. However, the Plan does not permit you to assign your right to sue to recover benefits under the Plan, to enforce rights due under the Plan, or to any other causes of action which you may have against the plan or its fiduciaries. Any attempt to assign such rights is void.

STATEMENT OF ERISA RIGHTS

All Participants in the Plan are entitled to certain rights and protections under ERISA. ERISA provides that all Participants shall be entitled to:

(i) Examine, without charge, at the Employer's office located at 1650 Corporate Circle Ste. 100, Petaluma, CA 94954 all Plan documents and copies of all documents which may be filed by the Plan with the U.S. Department of Labor.

(ii) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

If copies of any of the materials mentioned above are requested, and if such copies are not received within 30 days after the request, the Employee making the request may enforce their rights to such materials by filing suit in federal court. Unless the materials were not sent because of matters beyond the control of the Plan Administrator, they may be required to pay up to $110 for each day's delay until the materials are received.

In addition to creating rights for Employees who participate in the Plan, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan Participants and beneficiaries.

No one, including the Employer or any other person, may fire an Employee or otherwise discriminate against an Employee in any way to prevent the Employee from obtaining a benefit under the Plan or exercising their rights under ERISA.

If your claim for a benefit under the Plan 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 Plan 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 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.

If you have any questions about the 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.

QUESTIONS

If you have a question that is not answered here, ask the Plan Administrator or the Benefit Administrator. A complete copy of the Plan is available at the Plan Administrator's office if you wish to read it. Of course, the Plan itself, rather than this SPD, will control all rights under the Plan.