Summary of Temporary Material Modification #1 to the Amy's Kitchen Family Health Centers for Amy's Kitchen, Inc.

This Summary of Material Modifications ("SMM") modifies some of the information contained in the Summary Plan Description ("SPD") for the Employee Benefit Plan (the "Plan"). Note: In the event of any discrepancy between this SMM and the SPD, the provisions of this SMM will govern.

Modification(s)

1. **SECTION, SUMMARY PLAN DESCRIPTION; is amended to add the following:**

   COVID-19 (Novel Coronavirus)

   This is a temporary change effective only until sixty (60) days after the announced end of the National Emergency.

   In response to the Novel Coronavirus (COVID-19) pandemic, under the authority of section 518 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 7508A(b) of the Internal Revenue Code of 1986 (the code) have announced the extension of certain notice and disclosure requirements that impact Employee benefit plans. Under the Final Rule, all group health Plans must disregard the period of March 1, 2020 until sixty (60) days after the announced end of the National Emergency or such other date announced by the Agencies in a further notification ("Outbreak Period") for all Covered Persons, Beneficiaries, Qualified Beneficiaries or claimants, in determining the following periods:

   - The thirty (30) day (or sixty (60) day period, if applicable to request Special Enrollment under ERISA;
   - The sixty (60) day Election Period for COBRA continuation coverage;
   - The date for making COBRA premium payments;
   - The date for individuals to notify the plan of a Qualifying Event or determination of disability;
   - The date in which individuals may file a benefit claim under the Plan's Claims Procedure;
   - The date in which Covered Persons may file Appeals of an Adverse Benefit Determination under the Plan's Claims Procedure;
   - The date in which Covered Persons may file a request for an External Review after receipt of an Adverse Benefit Determination or Final Adverse Benefit Determination; and
   - The date within which a Covered Person may file information to perfect a request for External Review upon a finding that the request was not complete.

All other sections of the Plan remain unchanged.

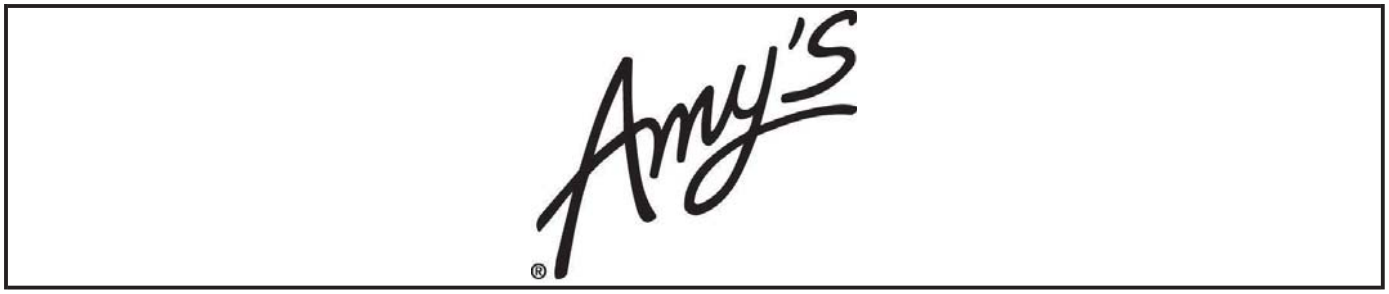
I, Carme Lewis, certify that I am the authorized agent of the Plan Administrator of the above-named Plan, and further certify that I am authorized to sign this Amendment. I have read and agree with the above change to the Plan and am hereby authorizing its implementation as of the effective date stated above.

Signature: Carme Lewis

Print Name: Carme Lewis

Date: January 1, 2021

If you have questions about these changes, please contact your Plan Administrator at 707-781-7625.



AMY'S KITCHEN, INC.

AMY'S KITCHEN FAMILY HEALTH CENTERS

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Effective Date: January 1, 2012
Update Date: January 1, 2021

TABLE OF CONTENTS

Effective Date: January 1, 2012
Update Date: January 1, 2021

Introduction

Maintaining your health and the health of your family is an important priority for Amy's Kitchen, Inc. To help you improve your health and well-being, we have designed the Amy's Kitchen Family Health Centers exclusively for Amy's Kitchen, Inc. employees and their families. Our goal is to make accessing health care easier by offering you convenient, affordable care right at your workplace.

Amy's Kitchen Family Health Centers are conveniently located near our plant sites and are designed to provide you and your qualified family members with high-quality, affordable and convenient health care, with a focus on wellness.

The Family Health Centers are:

- designed to be your primary source of health care to treat you when you are ill, and, more importantly, to keep you well;
- staffed with licensed medical providers and medical support personnel with bilingual (English/Spanish) capabilities;
- usually available with prepackaged starter medications (e.g., antibiotics or anti-inflammatory medications).

The Family Health Centers may provide services in addition to those covered under Amy's medical plans. This document is the Plan Document and Summary Plan Description for Amy's Kitchen Family Health Centers. It describes the basic features of the Family Health Centers and how they operate.

When the words "you" or ""your" are used throughout this document, it is a reference to Amy's Kitchen, Inc.'s eligible employees.

Family Health Center Locations

Santa Rosa, CA **2220 Northpoint Parkway Santa Rosa, CA 95407 Phone: 707-526-3180** **Monday – Thursday: 8:00am – 5:00pm** **Friday: 9:00am-6:00pm** **Email: amyssantarosa@verawholehealth.com**	**White City, OR** **393 W. Antelope Road White City, OR 97503** **Phone: Phone: 541-600-4610** **Monday – Thursday: 7:00am – 6:00pm** **Friday: 9:00am – 6:00pm** **Email: amysmedford@verawholehealth.com**	**Pocatello, ID** **219 Phil Meador Ave. Pocatello, ID 83202** **Phone: 208-810-4715** **Monday & Wednesday: 9:00am – 6:00pm** **Tuesday & Friday: 7:00am-3:00pm** **Thursday: 9:00am – 5:30pm** **Email: amyspocatello@verawholehealth.com**

*Employees will be notified should there be a change in Amy's Health Center's hours.

Eligibility

Employee Eligibility
All full or part-time active employees of Amy's Kitchen, Inc. (Amy's) are eligible to participate in the Amy's Kitchen Family Health Centers effective on their date of hire. Employees will be provided with the appropriate enrollment materials and information. An active election is required by the employee in order to participate in the Health Center.

Dependent Eligibility
Employees may enroll their eligible family members (dependents). Eligible dependents are defined as follows:

- Legal spouse or domestic partner
- Children up to age 26

Refer to section titled Definition of Eligible Dependents for a description of which family members are eligible. Appropriate documentation is required to show proof of relationship to the employee.

Definition of Eligible Dependents
An "eligible dependent" includes the following individuals:

A "spouse" who is your spouse under a legally valid existing marriage, unless court ordered separation exists.

A "domestic partner", who is your same or opposite sex, and who meets the following requirements:

- both you and your domestic partner must be at least eighteen (18) years of age and competent to enter into a contract;
- neither you nor your domestic partner are legally married to or the domestic partner of another person;
- neither you nor your domestic partner are legally separated from another person;
- neither you nor your domestic partner are related in any way that would prohibit marriage in the state of Amy's Kitchen, Inc.'s operations;
- you and your domestic partner have allowed at least six (6) months to pass since the termination of any previous domestic partnership (this does not apply if the previous domestic partnership ended due to the domestic partner's death); and
- you and your domestic partner share a permanent residence.

You must provide an Affidavit of Domestic Partnership to establish a domestic partner's eligibility. You must also provide an Affidavit of Domestic Partnership Termination when your domestic partnership terminates. You should contact Amy's Kitchen, Inc. for the required documentation.

A "child" who is your or your covered spouse's/domestic partner's natural child, stepchild, legally adopted child, child placed for adoption, foster child, and a child for whom you, the covered spouse or domestic partner has been appointed legal guardian or power of attorney for medical expenses, provided the child is less than twenty- six (26) years of age.

An eligible child also includes any other child of you or your spouse/domestic partner who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage. Amy's Kitchen, Inc. has established written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under Amy's Kitchen, Inc.'s health plans pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, Amy's Kitchen, Inc. will determine whether an order is a QMCSO, as defined in Section 609 of ERISA, or a NMSN, as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

Amy's Kitchen, Inc. reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency that issued the order, up to and including the right to seek a hearing before the court or agency.

A dependent child who was covered under the Plan prior to reaching the maximum age limit of twenty-six (26) years and who lives with you, is unmarried, incapable of self-sustaining employment and dependent upon you for support due to a mental and/or physical disability, will remain eligible for coverage under this Plan beyond the date coverage would otherwise terminate.

Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by Amy's Kitchen, Inc., but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

- cessation of the mental and/or physical disability;
- failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Termination of Coverage

Subject to any continuation rights under COBRA, coverage under the Plan automatically terminates on the earliest of the following dates:

1. Employee Coverage
    - the date Amy's Kitchen, Inc. terminates the Plan;
    - the last day of the month from the date you cease to meet the eligibility requirements of the Plan.
2. Dependent Coverage
    - the date Amy's Kitchen, Inc. terminates the Plan;
    - the last day of the month from the date you cease to meet the eligibility requirements of the Plan.
    - the date the Plan discontinues dependent coverage for all dependents or the class of dependents in which your dependent belongs.

Benefits and Services Provided

Amy's Kitchen Family Health Centers are self-administered workplace medical service facilities that provide outpatient health care services to you and your eligible dependents as described further in this document. Although Amy's Kitchen, Inc. sponsors and administers the Plan, Amy's Kitchen Family Health Centers are operated and managed by a separate company –Vera Whole Health. Vera Whole Health staffs, manages, and operates each Amy's Kitchen Family.

Health Center. Below are examples of the kinds of benefits and services of what each Family Health Center provides.

1. Preventive Care
    - Annual Physical Exams
    - Immunizations
2. Illness Treatment
    - Sore throat
    - Colds
    - Flu
    - Rash
    - Minor procedures (e.g. wart removal)
3. Injury Treatment
    - Stiches
    - Sprains
    - Strains
4. Chronic Condition and Illness Management
    - Diabetes
    - Asthma
    - Blood Pressure
    - Cholesterol
5. Coordination with Specialty Providers/Referrals
6. Telehealth Through VeraDirect

    Telehealth services are available for Amy's employees, spouses, and dependents (ages 3 and up) who are enrolled in health center benefits. Telehealth services for acute primary care needs are available 24 hours a day, 7 days a week, 365 days a year. Services are available using a smartphone, tablet, or computer.

Eligible members my access this service by downloading the VeraDirect app through the iOS app store or Google Play. VeraDirect may also be accessed by computer by visiting http://www.verdirect.comVera Whole Health is able to provide prescriptions to you and your eligible dependents for conditions being treated at Amy's Kitchen Family Health Center. Pediatric specialty services may be limited at Amy's Kitchen Family Health Centers. Vera Whole Health may refer your dependent children to a general pediatrician or other pediatric specialists, as needed. The type of services may change depending on how the attending physician is Board certified.

Accessing Services

If you are covered under this Plan, you may make an appointment at an Amy's Kitchen Family Health Center, in one of the following ways:

1. By Phone

To schedule an appointment by phone, call an Amy's Kitchen Family Health Center at the phone numbers listed on page 1 of this document.

2. In person

Visit an Amy's Kitchen Family Health Center in person at the locations listed on page 1 of this document.

3. Online

To schedule an appointment online, go to http://patients.verawholehealth.com to access convenient and secure online scheduling. In addition to online appointment scheduling, you have online access to secure messaging between you and your Vera Whole Health provider and your personal Vera Whole Health health records at https://www.nextmd.com. You will be asked to create a personal account before you will have access to these online features.

Your Cost for Family Health Center Benefits

There is no cost to you for any covered services or prescription medications that you or your eligible dependent receive at an Amy's Kitchen Family Health Center.

If a health center provider prescribes a medication not available in the health center and the member is enrolled in the Amy's Medical Plan, subscriber copays will be applied as outlined below:

(1) Generic − $5.00

(2) Brand Name − $10.00

(3) Formulary − $20.00

There are no deductibles under the Plan. There are also no lifetime or annual limits on the benefits you can receive under the Plan. Out-of-pocket maximums do not apply.

There is no cost or copay for eligible members to use the Telehealth service through VeraDirect, with the exception of spouses/dependents who may have a high deductible health plan with a health savings account through another employer.

Questions

If you have a question about whether a particular benefit or service is available under the Plan, you should first contact your local Amy's Kitchen Family Health Center directly and speak to a Vera Whole Health staff member. Vera Whole Health staff members can help answer questions about what benefits and services are available to you, taking into account the terms of this Plan. If you still have questions after speaking to a Vera Whole Health staff member, you should contact Amy's Kitchen, Inc. at the number set forth below under the section titled "Summary Plan Information."

Plan Administration

Amy's Kitchen, Inc. is the Plan Administrator of the Plan and a Named Fiduciary within the meaning of such terms as used in the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

As Plan Administrator, Amy's Kitchen, Inc. has the authority to interpret and construe the Plan regarding all questions of eligibility, the status and rights of any Plan participant under the Plan, and the manner, time, and provision of benefits under the Plan. You may be required from time to time, upon request of Amy's Kitchen, Inc., to furnish to Amy's Kitchen, Inc. the data and information as Amy's Kitchen, Inc. requires in the performance of its duties under the Plan.

Amy's Kitchen, Inc., in its sole and absolute discretion, may designate any individual, committee, or other independent agent as the Plan Administrator to carry out its duties and responsibilities with respect to the administration of the Plan. The designation must be in writing and will be kept with the records of the Plan. Amy's Kitchen, Inc. in its sole and absolute discretion may also designate a third-party agent for providing professional medical and/or management services for an Amy's Kitchen Family Health Center. The designation must be in writing and will be kept with the records of the Plan. Amy's Kitchen, Inc. has designated Vera Whole Health as the third- party agent to provide such professional medical and management services. Any duties not designated shall remain the sole responsibility of Amy's Kitchen, Inc. Amy's Kitchen, Inc. may adopt rules and procedures as it deems desirable for the administration of the Plan, provided that any of those rules and procedures must be consistent with provisions of the Plan, ERISA and other applicable laws.

Each Plan fiduciary shall discharge its duties solely in the interest of participants and for the exclusive purpose of providing benefits under the Plan to participants and defraying reasonable expenses of administering the Plan. Each Plan fiduciary, in carrying out such duties and responsibilities, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use.

Amy's Kitchen, Inc. intends to maintain the Plan indefinitely, but is under no obligation to continue the Plan and can amend or terminate the Plan at any time and for any reason.

Additional Health Plan Notices

A. Family and Medical Leave Act of 1993 (FMLA)

Notwithstanding any other Plan provision to the contrary, if you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA) (including a qualifying military leave under the FMLA), the following rules will apply. To the extent required by FMLA, Amy's Kitchen, Inc. will continue to maintain your benefits under this Plan on the same terms and conditions as though you were still an active employee. If your coverage under this Plan ceases during your FMLA leave (for example, because you opt to discontinue coverage or due to your nonpayment of your share of contributions), but you resume your coverage upon return from FMLA leave in accordance with the procedures and rules established by the Plan Administrator, you will have benefits under this Plan on the same terms as before you took your leave, or as otherwise required by the FMLA.

B. Qualified Medical Child Support Orders

This Plan will also provide benefits as required by any qualified medical child support order, as defined in ERISA Section 609(a) or a National Medical Support Notice. For a copy of Amy's Kitchen, Inc.'s procedures applicable to such notices, please contact Amy's Kitchen, Inc. The Plan also provides benefits to dependent children placed with Plan participants for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children in accordance with ERISA Section 609(c).

C. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we ask that you not provide any genetic information when responding to any request for medical information. "Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assisted reproductive services.

D. Notice of Availability of Privacy Practices

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

The Plan maintains a Notice of Privacy Practices that provides information to you about how protected health information will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Amy's Kitchen, Inc. The Notice describes the legal obligations of the Plan and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, the Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

Continuation of Coverage

In order to comply with federal regulations, this Plan includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This continuation of coverage may be commonly referred to as "COBRA coverage" or "continuation coverage." The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Self-administered workplace medical services facilities that provide outpatient health care services to you and your eligible dependents.

Qualifying Events

Qualifying events are any one of the following events that would cause a covered person to lose coverage under this Plan or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date described in Termination of Coverage:

1. Death of the employee.
2. The employee's termination of employment, or reduction in work hours to less than the minimum required for coverage under the Plan. This event is referred to below as an "18-Month Qualifying Event."
3. Divorce, legal separation from the employee or termination of domestic partnership.
4. The employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A dependent child no longer meets the eligibility requirements of the Plan.
6. The last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the employee informs the employer that he or she will not be returning to work.
7. The call-up of an employee reservist to active duty.

Notification Requirements

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered employee, termination of a domestic partnership or a child's loss of dependent status, the employee or dependent must submit a completed Qualifying Event Notification form to the plan administrator (or its designee) within sixty (60) days of the latest of:
   a) The date of the event;
   b) The date on which coverage under this Plan is or would be lost as a result of that event; or
   c) The date on which the employee or dependent is furnished with a copy of this Plan Document and Summary Plan Description.

   A copy of the Qualifying Event Notification form is available from the plan administrator (or its designee). In addition, the employee or dependent may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

   Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the plan administrator (or its designee) will notify the employee or dependent of his rights to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation of coverage results from any qualifying event under this Plan other than the ones described in Paragraph 1 above, the plan administrator (or its designee) will furnish an Election Notice to the employee or dependent not later than forty-four (44) days after the date on which the employee or dependent loses coverage under this Plan due to the qualifying event.

3. In the event it is determined that an individual seeking continuation of coverage (or extension of continuation coverage) is not entitled to such coverage, the plan administrator (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the Election Notice.
4. In the event an Election Notice is furnished, the eligible employee or dependent has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the Plan on the day before the qualifying event has the right to elect continuation of coverage on an individual

basis, regardless of family enrollment. If the employee or dependent chooses to have continuation coverage, he must advise the plan administrator (or its designee) of this choice by returning to the plan administrator (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the plan administrator (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

a) The date coverage under the Plan would otherwise end; or
b) The date the person receives the Election Notice from the plan administrator (or its designee).

5. Within forty-five (45) days after the date the person notifies the plan administrator (or its designee) that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance, on the first day each month.

Cost of Coverage

1. The Plan requires that covered persons pay the entire costs at the plan's maximum accrual rates, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the plan administrator (or its designee) by or before the first day of each month during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force.

2. For a person originally covered as an employee or as a spouse/domestic partner, the cost of coverage is the amount applicable to an employee if coverage is continued for himself alone. For a person originally covered as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an employee.

When Continuation Coverage Begins

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

Family Members Acquired During Continuation

A spouse/domestic partner or dependent child newly acquired during continuation coverage is eligible to be enrolled as a dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A dependent acquired and enrolled after the original qualifying event, other than a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

Extension of Continuation Coverage

1. In the event any of the following events occur during the period of continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a dependent's continuation coverage to be extended:
   a) Death of the employee.
   b) Divorce or legal separation from the employee.
   c) The child's loss of dependent status.

   Written notice of such event must be provided by submitting a completed Additional Extension Event Notification form to the plan administrator (or its designee) within sixty (60) days of the latest of:

   i. The date of that event;
   ii. The date on which coverage under this Plan would be lost as a result of that event if the first qualifying event had not occurred; or
   iii. The date on which the employee or dependent is furnished with a copy of this Plan Document and Summary Plan Description.

   A copy of the Additional Extension Event Notification form is available from the plan administrator (or its designee). In addition, the dependent may be required to promptly provide any supporting documentation as may be reasonably required for purposes of verification. Failure to properly provide the Additional Extension Event Notification and any requested supporting documentation will result in the person forfeiting their rights to extend continuation coverage under this provision. In no event will any extension of continuation coverage extend beyond thirty-six (36) months from the later of the date of the first qualifying event or the date as of which continuation coverage began. Only a person covered

prior to the original qualifying event or a child born to or placed for adoption with a covered employee during a period of COBRA coverage may be eligible to continue coverage through an extension of continuation coverage as described above. Any other dependent acquired
during continuation coverage is not eligible to extend continuation coverage as described above.

2. A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:
    a) That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtieth (60th) day of continuation coverage; and
    b) The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

    The disabled person (or his representative) must submit written proof of the Social Security Administration's disability determination to the plan administrator (or its designee) within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:
        i. The date of the disability determination by the Social Security Administration;
        ii. The date of the 18-Month Qualifying Event;
        iii. The date on which the person loses (or would lose) coverage under this Plan as a result of the 18-Month Qualifying Event; or
        iv. The date on which the person is furnished with a copy of this Plan Document and Summary Plan Description.

    Should the disabled person fail to notify the plan administrator (or its designee) in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation he or they would otherwise be entitled to, if any. The Plan may require that the individual pay one hundred and fifty percent (150%) of the cost of continuation coverage during the additional eleven (11) months of continuation coverage. In the event the Social Security Administration makes a final determination that the individual is no longer disabled, the individual must provide notice of that final determination no later than thirty (30) days after the later of:
    a) The date of the final determination by the Social Security Administration; or
    b) The date on which the individual is furnished with a copy of this Plan Document and Summary Plan Description.

End of Continuation

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months (or twenty-nine (29) months if continuation coverage is extended due to certain disability status as described above) from the date continuation began because of an 18-Month Qualifying Event or the last day of leave under the Family and Medical Leave Act of 1993.
2. Twenty-four (24) months from the date continuation began because of the call-up to military duty.
3. Thirty-six (36) months from the date continuation began for dependents whose coverage ended because of the death of the employee, divorce or legal separation from the employee, or the child's loss of dependent status.
4. The end of the period for which contributions are paid if the covered person fails to make a payment by the date specified by the plan administrator (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under this Plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."
5. The date coverage under this Plan ends and the employer offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.
6. The date the covered person first becomes entitled, after the date of the covered person's original election of continuation coverage, to Medicare benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.
7. The date the covered person first becomes covered under any other employer’s group health plan after the original date of the covered person's election of continuation coverage. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.
8. For the spouse/domestic partner or dependent child of a covered employee who becomes entitled to Medicare prior to the spouse’s/domestic partner's or dependent’s election for continuation coverage, thirty-six (36) months from the date the covered employee becomes entitled to Medicare.

Special Rules Regarding Notices

1. Any notice required in connection with continuation coverage under this Plan must, at minimum, contain sufficient information so that the plan administrator (or its designee) is able to determine from such notice the employee and dependent(s) (if any), the qualifying event or disability, and the date on which the qualifying event occurred.
2. In connection with continuation coverage under this Plan, any notice required to be provided by any individual who is either the employee or a dependent with respect to the qualifying event may be provided by a representative acting on behalf of the employee or the dependent, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.
3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:
    a) A single notice addressed to both the employee and the spouse/domestic partner will be sufficient as to both individuals if, on the basis of the most recent information available to the Plan, the spouse/domestic partner resides at the same location as the employee; and
    b) A single notice addressed to the employee or the spouse/domestic partner will be sufficient as to each dependent child of the employee if, on the basis of the most recent information available to the Plan, the dependent child resides at the same location as the individual to whom such notice is provided.

Military Mobilization

If an employee is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the employee and the employee's dependent may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA). When the leave is less than thirty-one (31) days, the employee and the employee's dependent may not be required to pay more than the employee's share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the plan administrator (or its designee) may require the employee and the employee's dependent to pay no more than one hundred and two percent (102%) of the full contribution. The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the employee fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty, the employee and the employee's dependent will be reinstated without a waiting period, regardless of their election of COBRA continuation coverage.

Plan Contact Information

Questions concerning this Plan, including any available continuation coverage, can be directed to the plan administrator (or its designee).

Address Changes

In order to help ensure the appropriate protection of rights and benefits under this Plan, covered persons should keep the plan administrator (or its designee) informed of any changes to their current addresses

Claims and Appeals

If you have a problem, complaint or claim, you must follow the procedures below to address your concerns or file a claim or appeal. There is no requirement under the Plan for you to obtain pre-authorization for any health benefit before Plan benefits will be provided under the Plan in accordance with its terms.

A. To Resolve a Problem

You should direct all initial questions and other informal complaints you have regarding health benefits under the Plan to Vera Whole Health at the Amy's Kitchen Family Health Center at which you or your eligible dependent plan to seek or have sought services. Here are some examples of reasons you might contact Vera Whole Health:

1. You have questions about what services are available to you under the Plan;
2. You believe you or your eligible dependent have been denied a service that is available to you under the Plan;
3. You are not satisfied with the quality of care you received;
4. You are dissatisfied with how long your appointment took, or how long you had to wait; or
5. You want to report unsatisfactory behavior by clinic staff members, or dissatisfaction with the condition of the clinic facilities.

If you are not satisfied with the response or decision you receive from Vera Whole Health, you may file a formal claim with the Plan Administrator.

B. When Health Claims Must Be Filed

The Plan Administrator has final authority for adjudicating all claims and appeals in accordance with the following provisions and with ERISA. Unless otherwise indicated, when used in these claims procedures, the term "day" means a calendar day.

You (or your duly authorized representative) must file any claim with the Plan Administrator within 90 days of the date services were incurred or denied. Claims filed later than that date will be denied, unless it is shown that it was not reasonably possible to file within 90 days, but in no event later than twelve (12) months from the date on which services were incurred or denied.

Your claim must be set forth in writing with all of the pertinent information you believe is relevant, and must also include the following information:

1. the date and type of service;
2. the location of the Amy's Kitchen, Inc. Family Health Center at which you received or sought services;
3. the name of the participant; and,
4. the name of the patient.

Your claim will be deemed filed when the Plan Administrator receives all of the above information. The Plan Administrator will determine if you have submitted enough information to decide the claim. If not, the Plan Administrator may request more information. The Plan Administrator must receive the additional information within 45 days from your receipt of the request for additional information. Failure to do so may result in claims being denied.

C. Timing of Claim Decisions

If you have provided all of the information needed to process the claim, the Plan Administrator will notify you of its decision within a reasonable period of time, but not later than 30 days after receipt of the claim.

This 30-day period may be extended for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you prior to the expiration of the initial 30-day processing period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension has been requested, the Plan Administrator will notify you of its decision prior to the end of the 15-day extension period.

If the extension described above is necessary because you have failed to submit the information necessary to decide the claim, the notice of extension must describe specifically the required information. You will be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

The period of time within which a benefit determination is required to be made will begin at the time a claim is deemed filed with the Plan in accordance with this section.

D. If Your Claim is Denied

If your claim for benefits is denied, you will receive an adverse benefit determination. You are entitled to a full and fair review of the adverse benefit determination. The adverse benefit determination may be in written or electronic form (in compliance with ERISA regulations), and will set forth:

1. information sufficient to identify the claim;
2. the specific reason for the denial;
3. specific references to the pertinent Plan provisions on which the denial is based including a copy of any internal guideline used in the benefit determination or notice of where and how you can obtain a copy free of charge;
4. a description of any additional material or information necessary for you to perfect the claim and an explanation as to why such information is necessary;
5. an explanation of the Plan's claims appeals procedures;
6. your right to bring a civil action under ERISA Section 502(a); and
7. if your claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or notice of where and how you can obtain a copy free of charge.

E. Your Right to Appeal

Within 180 days after the receipt of the adverse benefit determination, you have a reasonable opportunity to appeal the claim denial to the Plan Administrator for a full and fair review. You or your duly authorized representative may:

1. request a review by providing written notice to the Plan Administrator;
2. submit written comments, documents, records and other information relating to the claim; and,
3. upon request, have reasonable access to and copies of all documents, records, and other information relevant to the claim free of charge.

F. Timing of Notification of Benefit Determination on Review

The Plan Administrator will notify you of the Plan's benefit determination on review within a reasonable time, but not later than 60 days after receipt of the appeal. The period of time within which the Plan's determination is required to be made will begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

G. Review and Decision

The Plan Administrator, as a Plan fiduciary, will take into account all comments, documents, and other information submitted by you without regard to whether the information was submitted with the original claim and without

deference to the original determination. The person who reviews and decides an appeal will be a different individual than the person who made the initial benefit decision and will not be a subordinate of the person who made the initial claim decision. In the case of a claim denied on the grounds of medical judgment, the Plan Administrator will consult with a health care professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same individual who was consulted, if any, regarding the initial benefit decision or a subordinate of that individual. If the advice of a health care professional was obtained, the names of such individuals will be provided upon your request.

The decision of the Plan Administrator will be written and will include specific reasons for the decision, with specific references and copies of the pertinent Plan provisions or internal guideline on which the decision is based. You also have a right to bring a civil action under ERISA Section 502(a) following the denial of your appeal. You must exhaust the internal Plan claims review process as described in this Summary Plan Description before you may file a lawsuit. If your appeal is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, you will receive an explanation of the scientific or clinical judgment applied on the benefit determination or notice of where and how you can obtain a copy.

Summary Plan Information

Name of Plan:	Amy's Kitchen, Inc. Amy's Kitchen Family Health Centers
Name, Address and Phone Number of Employer/Plan Sponsor	Amy's Kitchen, Inc. 1650 Corporate Circle, Suite 100 Petaluma, CA 94954 Telephone: (707) 781-7625
Employer Identification Number:	68-0154899
Plan Number:	503
Type of Plan:	Welfare Benefit Plan
Plan Year:	January 1 through December 31
Effective Date of the Summary Plan Description:	January 1, 2021
Original Effective Date of Plan:	January 1, 2012
Source of Contributions:	Contributions for Plan expenses are obtained from Amy's Kitchen, Inc.'s general assets and any required employee contributions.
Funding Method:	The Plan is "self-funded." Amy's Kitchen, Inc. is responsible for the payment of the approved benefits and claims. Payment is made directly from general assets.
Effective Date of Coverage and Waiting Period:	Coverage under the Plan is effective on the date of hire. There is no waiting period.

Name, Address and Phone Number of Named Fiduciary and Plan Administrator	Amy's Kitchen, Inc. ATTN: Plan Administrator 1650 Corporate Circle, Suite 100 Petaluma, CA 94954 Telephone: (707) 781-7625
Agent for Service of Legal Process:	Amy's Kitchen, Inc. ATTN: Plan Administrator 1650 Corporate Circle, Suite 100 Petaluma, CA 94954 Telephone: (707) 781-7625 And Amy's Kitchen, Inc. ATTN: Office of General Counsel 1650 Corporate Circle, Suite 100 Petaluma, CA 94954 Telephone: (707) 781-7625
Third-Party Agent Professional and Management Services	Vera Whole Health 1511 6th Ave, Suite 260 Seattle, WA 98101

Statement of ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to the following.

A. Receive Information about Your Plan and Benefits

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 US. Department of Labor and available at the Public Disclosure Room of the Employee Benefit 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.

B. 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.

C. Reduction or Elimination of Exclusionary Periods

Receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your 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, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request if 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.

D. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan 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 Plan 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 welfare benefit or exercising your rights under ERISA.

E. Enforce Your Rights

If your claim for a 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.

F. 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.

ADOPTION STATEMENT

Amy's Kitchen, Inc. has caused this Family Health Centers Plan to take effect as of January 1, 2021 at Petaluma, California 94954.

I have read the document herein and certify the document reflects the terms and conditions of the Family Health Centers Plan as established by Amy's Kitchen, Inc.

Sign: Carme Lewis

Print: Carme Lewis

Date: January 1, 2021