# BAYADA HOME HEALTH CARE, INC. CAFETERIA PLAN

**ARTICLE I. Introductory Provisions**

BAYADA Home Health Care, Inc., ("the Employer") hereby amends the provisions of the BAYADA Home Health Care, Inc. Cafeteria Plan ("the Plan"), as amended, effective as of the date this document is executed. The Plan was originally effective July 1, 2007.

This Plan is designed to allow an Eligible Employee to pay for his or her share of Contributions on a pre-tax salary reduction basis under the Premium Payment Benefit Component, to an account for reimbursement of certain Medical Care Expenses (Health FSA Account), to an Employee's health savings account (HSA) and/or to an account for reimbursement of certain Dependent Care Expenses (DCAP Account).

This Plan is intended to qualify as a "cafeteria plan" under Code § 125 and the regulations issued thereunder. The terms of this document shall be interpreted to accomplish that objective.

The Health FSA Component is intended to qualify as a "self-insured medical reimbursement plan" under Code § 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 105(b). The DCAP Component is intended to qualify as a "dependent care assistance program" under Code § 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 129(a). Although reprinted within this document, the different components of this Plan shall be deemed separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed on such components by the Code. The Health FSA Component is a component benefit program of the BAYADA Home Health Care Inc. Health & Welfare Plan.

## ARTICLE II. Definitions

**"Account(s)"** means the Health FSA Accounts and the DCAP Accounts described in Section 7.5 for Health FSAs and Section 8.5 for DCAPs. In some contexts, the term "Account(s)" may also include the record of HSA Contributions described in Section 9.4.

**"Benefits"** means the Premium Payment Benefits, the Health FSA Benefits, the HSA Benefits and the DCAP Benefits offered under the Plan.

**"Benefit Package Option"** means a qualified benefit under Code § 125(f) that is offered through this Plan (such as the Premium Payment Benefits, the Health FSA, and DCAP), or an option for coverage for which pre-tax Salary Reductions may be used (i.e., the Welfare Benefits).

**"Change in Status"** has the meaning described in Section 4.6.

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

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

**"Contributions"** means the amount contributed to pay for the cost of Benefits, as calculated under Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits, Section 8.2 for DCAP Benefits and Section 9.2 for HSA Benefits.

**"Compensation"** means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code § 401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

**"Component"** means one of the benefit programs offered through this Plan. The Components of this Plan are set forth in Section 5.1.

**"DCAP"** means the dependent care assistance program described in Article VIII.

**"DCAP Account"** means the account described in Section 8.5.

**"DCAP Benefits"** has the meaning described in Section 8.1.

**"DCAP Component"** means the Component of this Plan described in Article VIII.

**"Dependent"** means: (a) for purposes of accident or health coverage and to the extent funded for purposes of the Health FSA Component and under the Premium Payment Component , 1) any individual who is a tax dependent of the Participant as defined in Code § 105(b), 2) any child (as defined in Code § 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year) ; and (b) for purposes of the DCAP Component, a dependent means a Qualifying Individual as defined in Section 8.3(c).

The Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent." Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

**"Dependent Care Expenses"** has the meaning described in Section 8.3.

**"Effective Date"** of this Plan has the meaning described in Article 1.

**"Election Form/Salary Reduction Agreement"** means the form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following: Premium Payment Benefits, Health FSA Benefits, HSA Benefits and DCAP Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

**"Eligible Employee"** means an Employee eligible to participate in this Plan, as provided in Section 3.1.

**"Employee"** means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: exclude any leased employee; exclude any temporary employee; exclude any self-employed individual; exclude any partner in a partnership; exclude any more-than-2% shareholder in a Subchapter S corporation; and exclude any employee of a collective bargaining agreement The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

**"Employer"** means BAYADA Home Health Care, Inc., and any Related Employer that adopts this Plan with the approval of BAYADA Home Health Care, Inc. Related Employers that have adopted this Plan, if any, are listed in Appendix A of this Plan. However, for purposes of Article XIV and Section 15.3, "Employer" means only BAYADA Home Health Care, Inc.

**“Employment Commencement Date”** means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

**“ERISA”** means the Employee Retirement Income Security Act of 1974, as amended.

**“FMLA”** means the Family and Medical Leave Act of 1993, as amended.

**“General-Purpose Health FSA Option”** has the meaning described in Section 7.3(b).

**“Health FSA”** means health flexible spending arrangement, which consists of four options (if applicable): the General- Purpose Health FSA Option; the Limited (Vision/Dental/Preventive Care) Health FSA Option; the Employee- Only Health FSA Option; and the Employee-Plus-Children Health FSA Option.

**“Health FSA Account”** means the account described in Section 7.5.

**“Health FSA Benefits”** has the meaning described in Section 7.1.

**“Health FSA Component”** means the Component of this Plan described in Article VII.

**“High Deductible Health Plan”** means the high deductible health plan offered by the Employer that is intended to qualify as a high deductible health plan under Code § 223(c)(2), as described in materials provided separately by the employer.

**“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, as amended.

**“HSA”** means a health savings account established under Code § 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

**“HSA Benefits”** has the meaning described in Section 9.1.

**“HSA-Eligible Individual”** means an individual who is eligible to contribute to an HSA under Code § 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer.

**“Limited (Vision/Dental/Preventive Care) Health FSA Option”,** has the meaning described in Section 7.3(b).

**“Medical Care Expenses”** has the meaning defined in Section 7.3.

**“Nonelective Contribution(s)”** means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Spouse and Dependents, if applicable, under one or more of the Benefits offered under the Plan. The amount of Employer contribution that is applied towards the cost of the

Reimbursement Account benefits(s) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer. The amount of Nonelective Contribution for each Participant may be adjusted upward or downward in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's Dependent status, commencement, or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. To the extent set forth in the SPD or enrollment material, the Employer may make Nonelective Contributions available to Participants and allow Participants to allocate the Nonelective Contributions among the various Benefits offered under the Plan in a manner set forth in the SPD of additional, taxable Compensation except as otherwise provided in the SPD or enrollment material.

**"Open Enrollment Period"** with respect to a Plan Year means the month preceding the Plan Year, or such other period as may be prescribed by the Administrator.

**"Participant"** means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include (a) those who elect one or more of the Welfare Benefits, Health FSA Benefits, DCAP Benefits, HSA Benefits, and Salary Reductions to pay for such Benefits; and (b) those who elect instead to receive their full salary in cash and to pay for their share of their Contributions under a Welfare Benefit with after-tax dollars outside of this Plan and who have not elected any Health FSA Benefits, DCAP Benefits or HSA Benefits.

**"Period of Coverage"** means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

**"Plan"** means the BAYADA Home Health Care, Inc. Cafeteria Plan as set forth herein and as amended from time to time.

**"Plan Administrator"** means BAYADA Home Health Care, Inc.

**"Plan Year"** means, for all periods prior to July 1, 2023, the 12-month period commencing July 1 and ending on June 30. The Plan Year that begins on July 1, 2023 shall be a short plan year that ends on December 31, 2023. Effective as of January 1, 2024, the Plan Year shall be the calendar year.

**"Premium Payment Benefits"** means the Premium Payment Benefits that are paid for on a pretax Salary Reduction basis as described in Section 6.1.

**"Premium Payment Component"** means the Component of this Plan described in Article VI.

**"QMCSO"** means a qualified medical child support order, as defined in ERISA § 609(a).

**“Qualifying Dependent Care Services”** has the meaning described in Section 8.3.

**“Qualifying Individual”** has the meaning described in Section 8.3.

**“Related Employer”** means any employer affiliated with BAYADA Home Health Care, Inc. that, under Code § 414(b), § 414(c), or § 414(m), is treated as a single employer with BAYADA Home Health Care, Inc. for purposes of Code § 125(g)(4).

**“Salary Reduction”** means the amount by which the Participant’s Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable Component, before any applicable state and/or federal taxes have been deducted from the Participant’s Compensation (i.e., on a pre-tax basis).

**“Spouse”** means an individual who is treated as a spouse for federal tax purposes. Notwithstanding the foregoing, for purposes of the DCAP Component the term “Spouse” shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

**“Welfare Benefit”** shall mean an employee benefit program offered through the BAYADA Home Health Care Inc. Health & Welfare Plan.

## ARTICLE III. Eligibility and Participation

### 3.1 Eligibility to Participate

An Employee who is eligible to participate in and receive benefits under one or more of the Benefit Package Options is eligible for this Plan. Eligibility for any particular Benefit Package Option will be determined solely in accordance with the terms of such program. An Employee who is eligible for this Plan begins participating in this Plan upon his or her participation in a Benefit Package Option solely in accordance with the terms of such program. More detailed information regarding enrollment procedures, including when coverage begins and ends, is set forth in the documents governing the Benefit Package Options. To participate in the HSA Component, the individual must be an HSA-Eligible Individual and shall also be subject to the additional requirements, if any, specified in the High Deductible Health Plan. Once an Employee has met the Plan’s eligibility requirements, the Employee may elect coverage in accordance with the procedures described in Article IV.

### 3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

- the termination of this Plan; or

- the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, certain Employees may continue eligibility in the Health FSA pursuant to COBRA.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Welfare Benefits will terminate as of the date specified in the applicable Welfare Benefit. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to Section 7.8 for Health FSA Benefits and Section 8.8 for DCAP Benefits. Distributions from a Participant's HSA (whether before or after termination of employment) and all other matters relating to a Participant's HSA are outside of this Plan and are to be handled by the Participant and his or her trustee/custodian in accordance with the agreement between them—see Article IX.

### 3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination.

### 3.4 FMLA Leaves of Absence

The Plan shall be administered in accordance with the FMLA, to the extent applicable.

## ARTICLE IV. Method and Timing of Elections; Irrevocability of Elections

### 4.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan mid-year may elect to commence participation in one or more Benefits after the eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the first day of the month in which participation will commence. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described in Article IV.

The Welfare Benefits for which a Participant pays pursuant to the Premium Payment Benefit shall be subject to the additional requirements, if any, specified in the applicable Welfare Benefit. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Welfare Benefit plan documents and summary plan descriptions.

### 4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a midyear election change, as described in Article IV.

### 4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.1 and 4.2, then the Employee may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described in Article IV.

### 4.4 Irrevocability of Elections

Unless an exception applies (as described in Article IV), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

Unless otherwise noted in this section, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding: participation in this Plan;

- Salary Reduction amounts; or
- election of particular Benefit Package Options(including the various Health FSA Options).

Notwithstanding the foregoing, an election to make a Contribution to an HSA can be changed at any time on a prospective basis.

**4.5 Procedure for Making New Election If Exception to Irrevocability Applies**

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 4.6 or 4.7, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 4.7(d) through 4.7(i), within 30 days after the events described in such Sections). Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under a Welfare Benefit shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

*(b) Effective Date of New Election.* Elections made pursuant to this Section 4.5 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 4.7(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Welfare Benefit commences later).

*(c) Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP Components see Section 7.4 and Section 8.4 respectively.

### 4.6 Change in Status Defined

A Participant may make a new election upon the occurrence of certain events as described in Section 4.7, including a Change in Status, for the applicable Component. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

*(a) Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

*(b) Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

*(c) Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

*(d) Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and



*(e) Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents (but only if such change in residence impacts eligibility for such benefit).

### 4.7 Other Events Permitting Exception to Irrevocability Rule for Other Benefits (Except as Otherwise Indicated) Other than HSA Benefits

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Component of this Plan:

*(a) Open Enrollment Period (Applies to Premium Payment, Health FSA, and DCAP Benefits)* A Participant may change an election during the Open Enrollment Period.

*(b) Termination of Employment (Applies to Premium Payment, Health FSA, and DCAP Benefits)* A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.2 and 3.3, as applicable.

*(c) Leaves of Absence (Applies to Premium Payment, Health FSA, and DCAP Benefits)* A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

*(d) Change in Status (Applies to Premium Payment, Health FSA as Limited Below, and DCAP Benefits as Limited Below)* A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 4.6), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

Election changes may be made to reduce Health FSA coverage during a Period of Coverage or to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

*(1) Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for: (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health

plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

*(2) Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

*(3) Special Consistency Rule for DCAP Benefits.* With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if: (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code § 129.

(e) *HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits, but Not to Health FSA or DCAP Benefits).* If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

- a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or

- a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days, unless such deadline has been suspended as required by temporary federal relief related to the ongoing COVID-19 national emergency declaration).

For purposes of this Section 4.7(e), the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

*(f) Certain Judgments, Decrees and Orders (Applies to Premium Payment and Health FSA Benefits, but Not to DCAP Benefits).* If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

*(g) Medicare and Medicaid (Applies to Premium Payment and Health FSA Benefits as limited below, but Not to DCAP Benefits).* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be canceled (but not reduced). Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

(h) *Change in Cost (Applies to Premium Payment Benefits, DCAP Benefits as Limited Below, but Not to Health FSA Benefits).* For purposes of this Section 4.7(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

*(1) Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

*(2) Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage ( not including the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

*(3) Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Package Option significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in

another Benefit Package Option (not including the Health FSA) may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost; or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

*(4) Limitation on Change in Cost Provisions for DCAP Benefits.* The above "Change in Cost" provisions (Sections 4.7 (h)(1) through 4.7(h)(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§ 152(d)(2)(A) through (G), incorporating the rules of Code §§ 152(f)(1) and 152(f)(4).

(i) *Change in Coverage (Applies to Premium Payment and DCAP Benefits as Limited Below, but Not to Health FSA Benefits).* The definition of "similar coverage" under Section 4.7(h) applies also to this Section 4.7(i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (not including the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

*(b) Significant Curtailment With a Loss of Coverag*e. If the Plan Administrator determines that a Participant's Benefit Package Option coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides

similar coverage (not including the Health FSA) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

*(c) Definition of Loss of Coverage.* For purposes of this Section 4.7(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option;
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

*(3) Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

*(4) Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made

under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

*(5) DCAP Coverage Changes.* A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, then the Participant may cancel coverage.

*(6) Revocation of Medical Coverage Due to Reduction in Hours.* A participant may revoke his or her major medical coverage, along with that of any related individuals, if the Participant experiences a reduction of hours such that he or she will be reasonably expected to work fewer than 30 hours a week on a regular basis and the Participant intends to enroll, along with any such related individuals, in another medical plan no later than the first day of the second full month following the revocation.

*(7) Revocation of Medical Coverage for Purposes of Enrolling in Marketplace Coverage.* A participant may revoke his or her major medical coverage if he or she is seeking to enroll, along with that of any related individuals who cease coverage due to such revocation, in Marketplace coverage (either during the Marketplace's annual open enrollment period or during a special enrollment period) immediately after the revoked coverage ends.

A Participant entitled to change an election as described in this Section 4.7 must do so in accordance with the procedures described in Section 4.5.

**4.8 Election Modifications for HSA Benefits May Be Changed Prospectively at Any Time**

As set forth in Section 9.1, an election to make a Contribution to an HSA can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the first day of the next calendar month following the date that the election change was filed. No Benefit Package Option election changes can occur as a result of a change in HSA election except as otherwise described in this Article IX. For example, a

Participant generally would not be able to terminate an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described in Section 4.7 for Health FSAs otherwise applied (such as for change in status).

A Participant entitled to change an election as described in this Section 4.7 must do so in accordance with the procedures described in Section 4.5.

**4.9 Election Modifications Required by Plan Administrator**

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions (including Salary Reductions for HSA Benefits) for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

## ARTICLE V. Benefits Offered and Method of Funding

### 5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect one or more of the following Benefits:

- Premium Payment Benefits, as described in Article VI;
- Health FSA Benefits, as described in Article VII. The Health FSA election may be for the General-Purpose Health FSA Option or the Limited (Vision/Dental/Preventive Care) Health FSA Option
- HSA Benefits as described in Article IX;
- DCAP Benefits, as described in Article VIII.

In no event shall Benefits under the Plan be provided in the form of deferred compensation.

### 5.2 Using Salary Reductions to Make Contributions

*Salary Reductions per Pay Period*. The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (as described in Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits, Section 9.2 for HSA Benefits, and Section 8.2 for DCAP Benefits, as applicable), divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate).
If a Participant increases his or her election under the Health FSA Component, HSA Component or DCAP Component to the extent permitted under Section 4.7, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 4.7, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).

*Considered Employer Contributions for Certain Purposes*. Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium

Payment Benefits, Health FSA Benefits, HSA Benefits, and the DCAP Benefits and, for the purposes of this Plan and the Code, may be considered to be Employer contributions.

*Salary Reduction Balance Upon Termination of Coverage*. If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation, to the extent permitted by state law.

*After-Tax Contributions for Premium Payment Benefits*. For those Participants who elect to pay their share of the Contributions for any of the Welfare Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

**5.4 Funding This Plan**

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but the benefits provided through the Welfare Benefits that are paid pursuant to the Premium Payment Benefits shall be paid as provided in the applicable Welfare Benefit plan document or summary plan description. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected (a) as Employer and Participant Contributions for Premium Payment Benefits, as described in Section 6.2; and (b) as described under Section 7.4(b) for Health FSA Benefits, Section 8.4(b) for DCAP Benefits, and Section 9.2 for HSA Benefits.

## ARTICLE VI. Premium Payment Component

### 6.1 Benefits

The Premium Payment Component offers Eligible Employees the opportunity to use pre-tax Salary Reductions to pay their share of certain benefits provided through the BAYADA Home Health Care, Inc. Health & Welfare Plan (each a "Welfare Benefit"). The Welfare Benefits themselves are subject to the plan documents governing such benefits, and no changes can be made with respect to such benefits (such as mid-year changes in election) if such changes are not permitted under the applicable benefit.

An Eligible Employee can (a) elect benefits under the Premium Payment Component by electing to pay for his or her share of the Contributions for Welfare Benefits on a pretax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Component and to pay for his or her share of the Contributions, if any, for Welfare Benefits with after-tax deductions outside of this Plan. Unless an exception applies (as described in Article IV), such election is irrevocable for the duration of the Period of Coverage to which it relates.

At its discretion, the Employer may offer cash in lieu of benefits.

### 6.2 Contributions for Cost of Coverage

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer in its sole discretion. The Contribution amounts shall be communicated to Eligible Employees prior to the beginning of each Plan Year.

**ARTICLE VII. Health FSA Component**
**7.1 Health FSA Benefits**

An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses from the Health FSA (Health FSA Benefits); and (b) to pay the Contribution for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article IV), any such election is irrevocable for the duration of the Period of Coverage to which it relates.

**7.2 Contributions for Cost of Coverage of Health FSA Benefits**

The annual Contribution for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant and any Nonelective Contributions allocated thereto by the Employer, subject to the dollar limits set forth in Section 7.4(b).

**7.3 Eligible Medical Care Expenses for Health FSA**

Under the Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force.
*(a) Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the medical care.

*(b) Medical Care Expenses.* "Medical Care Expenses" will vary depending on which Health FSA coverage option the Participant has elected. Contact the Plan Administrator for complete information about whether a particular expense is eligible for reimbursement from the FSA. Please note that there are special rules for certain services, such as orthodontia.

- General-Purpose Health FSA Option. For purposes of this Option, "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213(d)—provided, however, that this term does not include expenses that are excluded under this Plan, nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through major medical coverage, other insurance, or any other accident or health plan.

If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Participant's major medical coverage imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VII.

HSA Benefits cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA Option is selected. In addition, a Participant who has an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Option) that is in effect on the last day of a Plan Year cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's Health FSA Account is $0 as of the last day of that Plan Year. For this purpose, a Participant's Health FSA Account balance is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

**7.4 Maximum and Minimum Benefits for Health FSA**

(a*) Maximum Reimbursement Available; Uniform Coverage.* The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8 . Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VII have been satisfied.

*(b) Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be communicated to the Participant prior to the beginning of the Plan Year. Such limit shall comply with the IRS' annual contribution limits. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $0.00. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

*(c) Changes; No Proration.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the Health FSA Component mid-year or wishes to increase his or her election mid-year as permitted under Section 4.7, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.

*(d) Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article IV (other than for FMLA leave) that increases contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

**7.5 Establishment of Health FSA Account**

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose.

The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

*(a) Crediting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

*(b) Debiting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period.

*(c) Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage (or during the Grace Period, if applicable); it is not based on the amount credited to the Health FSA Account at a particular point in time . Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

### 7.6 Unused Funds

(a) *Rollover of Unused Funds.* If any balance remains in the Participant's Health FSA Account with respect to a Period of Coverage after all reimbursements have been made for that Period of Coverage (including any reimbursements made during a run-out period), then any such balance up to $500.00 shall be carried over to reimburse the Participant for Medical Care Expenses incurred during the subsequent Plan Year, provided that the Participant has not exercised his or her right to waive any right to any such carryover and provided that the Employer does not require an election for the subsequent Plan Year. Notwithstanding the foregoing, the Participant shall forfeit all rights with respect to any such balance above $500.00.

(b) Use *of Forfeitures.*

All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

### 7.7 Reimbursement Claims Procedure for Health FSA

*(a) Timing.*

Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim. The time for filing a claim for reimbursement may be temporarily suspended as required by temporary federal relief relating to the ongoing COVID-19 national emergency declaration; contact the Plan Administrator for more information.

*(b) Claims Substantiation.*

A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the 3 month(s) following the close of the Plan Year in which the Medical Care Expense was incurred (except that for a Participant who ceases to be eligible to participate, this must be done no later than 3 month(s) after the date that eligibility ceases, as described in Section 7.8). The request for reimbursement may require the Participant to include information such as:

- the person(s) on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

The Plan Administrator may require the Participant to submit bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request.

If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43, IRS Notice 2006-69, or other IRS guidance.

*(c) Claims Denied.* For reimbursement claims that are denied, see the appeals procedure described in in Article XIII.

*(d) Claims Ordering; No Reprocessing.* All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

**7.8 Reimbursements From Health FSA After Termination of Participation; COBRA**

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible (provided that the Participant (or the Participant's estate) files a claim within 3 month(s) after the date that the Participant ceases to be a Participant. Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA.

Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5(a) and Section 7.5(b) without regard to Section 7.5(c), they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health FSA Benefits shall be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

**7.9 Coordination of Benefits.** Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the Health FSA shall not be considered to

be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

Notwithstanding the foregoing, however, in the event that an expense is eligible for reimbursement under both the Health FSA and the HSA, the Participant may choose to seek reimbursement from either the health FSA or the HSA, but not both.

A general-purpose health FSA constitutes family coverage because it is available to pay or reimburse the qualified medical expenses of the employee and the employee’s spouse and dependents. Consequently, if either spouse participates in a general-purpose health FSA, neither spouse will be eligible to contribute to an HSA either through the spouse’s employer or individually through a bank, unless the HSA contribution is limited to self-only coverage. Likewise, the fact that an adult child's qualified medical expenses could be reimbursed by a parent's general-purpose health FSA (i.e., because the child is under age 27 as of the end of the taxable year) will prevent the adult child from being HSA-eligible.

## ARTICLE VIII. DCAP Component

### 8.1 DCAP Benefits

An Eligible Employee can elect to participate in the DCAP Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses and to pay the Contribution for such benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article IV), such election of DCAP Benefits is irrevocable for the duration of the Period of Coverage to which it relates.

### 8.2 Contributions for Cost of Coverage for DCAP Benefits

The annual Contribution for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 8.4(b). (For example, if the maximum $5,000.00 annual benefit amount is elected, then the annual Contribution amount is also $5,000.00.)

### 8.3 Eligible Dependent Care Expenses

Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

*(a) Incurred.*

A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

*(b) Dependent Care Expenses.*

"Dependent Care Expenses" are expenses that are considered to be employment-related expenses under Code § 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any, and expenses for incidental household services), if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services—provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VIII.

*(c) Qualifying Individual.*

"Qualifying Individual" means:

- a tax dependent of the Participant as defined in Code § 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code § 152(a)(1);
- a tax dependent of the Participant as defined in Code § 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or
- a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code § 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code § 152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

*(d) Qualifying Dependent Care Services.*

"Qualifying Dependent Care Services" means the following: services that both (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed:

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household.

In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

*(e) Exclusion.*

Dependent Care Expenses do not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code § 151(c) to a Participant or his or her Spouse;
- a Participant's Spouse;

- a Participant’s child (as defined in Code § 152(f)(1)) who is under l9 years of age at the end of the year in which the expenses were incurred; or
- a parent of a Participant’s under age 13 qualifying child (as defined in Code § 152(a)(1)).

### 8.4 Maximum and Minimum Benefits for DCAP

(a) *Maximum Reimbursement Available.*

The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant’s DCAP Account pursuant to Section 8.5. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant’s Account (that is, the year-to-date amount that has been withheld from the Participant’s Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements).) Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant’s election is effective, provided that the other requirements of this Article VIII have been satisfied.

(b) *Maximum and Minimum Dollar Limits.*

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $0.00. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $5,000.00 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of the applicable statutory limit for the Participant as set forth in applicable federal tax regulations.

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $0.00.

(c) *Changes; No Proration.*

For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the DCAP Component midyear or wishes to increase his or her election mid-year as permitted under Section 4.7, then there will be no proration rule—i.e., the Participant may elect coverage up

to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.

(d) *Effect on Maximum Benefits If Election Change Permitted.*

Any change in an election under Article IV affecting annual contributions to the DCAP Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Sections 8.4(a) and (b). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions, if any, made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCAP Account, reduced by (3) reimbursements during the Period of Coverage.

**8.5 Establishment of DCAP Account**

The Plan Administrator will establish and maintain a DCAP Account with respect to each Participant who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 8.6.

(a) *Crediting of Accounts.*

A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.
Debiting of Accounts.

A Participant's DCAP Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

(b) *Available Amount Is Based on Credited Amount.*

As described in Section 8.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements (i.e., it is based on the amount credited to the DCAP Account at a particular point in time). Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

### 8.6 Forfeiture of DCAP Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any DCAP Account benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

### 8.7 Reimbursement Claims Procedure for DCAP

*(a) Timing.*

Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

*(b) Claims Substantiation.*

A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the 3 month(s) following the close of the Plan Year in which the Dependent Care Expense was incurred (except for a Participant who ceases to be eligible to participate, by no later than 3 month(s) after the date that eligibility ceases, as described in Section 9.8) in the form and manner required by the Administration. This may require the Participant to set forth information that includes:

- the person(s) on whose behalf Dependent Care Expenses have been incurred;

- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- the name of the person, organization or entity to whom the Expense was or is to be paid, and
- taxpayer identification number (Social Security number, if the recipient is a person);
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;
- the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 8.4(b); and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).
- The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request.

*(c) Claims Denied.*

For reimbursement claims that are denied, see the appeals procedure in Article XIII.

**8.8 Reimbursements From DCAP After Termination of Participation**

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible provided that the Participant (or the Participant's estate) files a claim within 3 month(s) after the date that the Participant's employment terminates or the Participant otherwise ceases to be eligible.

**8.9 Report to DCAP Participants**

On or before January 31 of each year, the Plan Administrator shall furnish to each Participant who has received reimbursement for Dependent Care Expenses during the prior calendar year a written or electronic statement (such as Form W-2) showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the Salary Reductions for the year for the DCAP Component, as the Plan Administrator deems appropriate.

## ARTICLE IX. HSA Component

### 9.1 HSA Benefits

An Eligible Employee can elect to participate in the HSA Component by electing to pay the Contributions on a pre-tax Salary Reduction basis to the Employee's HSA established and maintained outside the Plan by a trustee/custodian to which the Employer can forward Contributions to be deposited (this funding feature constitutes the HSA Benefits offered under this Plan). As described in Article IV, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

An Eligible Employee may not contribute to an HSA while simultaneously covered by medical benefits that are not considered a "high-deductible health plan." Further, no HSA Contributions may be made if the Eligible Employee is simultaneously covered under the Health FSA Component unless the Limited (Vision/Dental/Preventive Care) Health FSA Option is selected. Participants in a non-Limited FSA Option will not be HSA eligible until the first of the month following the end of the Health FSA Plan Year. In addition, a Participant who is entitled to a grace period under Health FSA (other than the Limited (Vision/Dental/Preventive Care) Health FSA Option) with a year-end balance is ineligible for HSA contributions until the first calendar month following the grace period end date.

### 9.2 Contributions for Cost of Coverage for HSA; Maximum Limits

The annual Contribution for a Participant's HSA Benefits is equal to the annual benefit amount elected by the Participant. In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the Contribution is made.

An additional catch-up Contribution may be made for Participants who are age 55 or older. In addition, the maximum annual contribution shall be: (a) reduced by any matching (or other) Employer contribution made on the Participant's behalf (there are currently no such Employer contributions (other than pre-tax Salary Reductions) made under the Plan); and (b) pro-rated for the number of months in which the Participant is an an HSA-Eligible Individual.

It shall be the Participant's sole responsibility to maintain compliance with the HSA contribution limits and to seek counsel from their personal tax advisor, if necessary.

### 9.3 Recording Contributions for HSA

As described in Section 9.5, the HSA is not an employer-sponsored employee benefit plan; it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The HSA trustee/custodian will be chosen by the Participant, not by the Employer. The Employer may, however, limit the number of HSA providers to whom it will forward contributions that the Employee makes via pre-tax Salary Reductions, and such a list is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA Contributions an Employee makes via pre-tax Salary Reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in a HSA.

**9.4 Tax Treatment of HSA Contributions and Distributions**

The tax treatment of the HSA (including contributions and distributions) is governed by Code § 223. The Employer does not provide tax advice; it shall be the sole responsibility of the Participant to seek advice from their personal tax advisor.

**9.5 HSA Not Intended to Be an ERISA Plan**

HSA Benefits under this Plan consist solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax Salary Reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

## ARTICLE X. HIPAA PROVISIONS FOR HEALTH FSA

### 10.1 Provision of Protected Health Information to Employer

Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Health FSA. When this health information is provided from the Health FSA to the Employer, it may be considered Protected Health Information ("PHI"). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. "Protected Health Information" shall be defined as set forth in HIPAA.

The Employer shall have access to PHI from the Health FSA only as permitted under this Article X or as otherwise required or permitted by HIPAA.

### 10.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Health FSA may disclose to the Employer information on whether the individual is participating in the Plan.

### 10.3 Permitted Uses and Disclosure of Summary Health Information

The Health FSA may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Health FSA.

"Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

### 10.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 10.5 and obtaining written certification pursuant to Section 10.7, the Health FSA may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes.

"Plan administration purposes" means administration functions performed by the Employer on behalf of the Health FSA, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the

Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

**10.5 Conditions of Disclosure for Plan Administration Purposes**

The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Health FSA, the Employer shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health FSA agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make available PHI to comply with HIPAA’s right to access in accordance with 45 CFR § 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health FSA available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with HIPAA’s privacy requirements;
- if feasible, return or destroy all PHI received from the Health FSA that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that the adequate separation between the Health FSA and the Employer (i.e., the “firewall”), required in 45 CFR § 504(f)(2)(iii), is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Health FSA, it will implement administrative, physical, and technical safeguards that reasonably and

appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Health FSA any security incident of which it becomes aware.

**10.6 Adequate Separation Between Plan and Employer**

The Employer shall allow the following persons access to PHI: Area Director for Health and Welfare; the Director of Health and Welfare; Benefits Manager for Health and Welfare; members of the Health and Welfare Benefits Team; and any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Health FSA (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Health FSA. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section 10.6 are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

**10.7 Certification of Plan Sponsor**

The Health FSA shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 10.5.

## ARTICLES XI and XII. RESERVED

## ARTICLE XIII. Appeals Procedure

### 13.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedure set forth in the summary plan description for this Plan. Unless otherwise set forth in this Plan or in the terms of a Welfare Benefit plan document, the Committee acts on behalf of the Plan Administrator with respect to appeals.

### 13.2 Procedure if Benefits Are Denied Under the Health FSA Component

If a claim for reimbursement from the Health FSA Component is denied, the applicable claims administrator shall provide a written notice of denial within 30 days of the date the claim form was submitted. Such notification will (1) state the reason why the claim was denied, (2) explain what steps, if any, can be taken to validate the claim and, (3) describe the right to request an administrative review of the claim denial.

The claimant shall have 180 days to request a review of a denied claim. The claimant (and/or the claimant's authorized representative) will have the opportunity to review any important documents held by the claims administrator and to submit comments and other supporting information. In most cases, a decision will be reached within 30 days of the date of the appeal.

If the appeal is denied, the claims administrator will provide a written explanation that describes the right to file a civil claim under ERISA to challenge the denial. Any civil action must be filed within one year after the date of the final denial.

Complete information regarding the appeals procedures shall be provided by the claims administrator for the Health FSA Component.

### 13.3 Procedure if Benefits Are Denied Under the DCAP Component

If a claim for benefits under the DCAP Component is denied, it shall be administered in accordance with the claims procedures established by the applicable claims administrator.

### 13.4 Claims Procedures for All Other Welfare Benefits

Claims and reimbursement for all other Welfare Benefits shall be administered in accordance with the claims procedures for such benefit, as set forth in the applicable plan documents and/or summary plan description.

## ARTICLE XIV. Recordkeeping and Administration

### 14.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

### 14.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

- to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 13.1);
- to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;
- to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;
- to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
- to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant’s Compensation has been reduced in order to provide benefits under this Plan;
- to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;
- to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

- to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;
- to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and
- to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

**14.3 Reliance on Participant, Tables, etc.**

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

**14.4 Provision for Third-Party Plan Service Providers**

The Plan Administrator, subject to approval of the Employer, may contract for the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

**14.5 Compensation of Plan Administrator**

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

**14.6 Bonding**

The Plan Administrator shall be bonded to the extent required by ERISA, if and/or when any claims are not funded by the employer's general assets.

**14.9 Insurance Contracts**

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to

the extent that such amounts are less than aggregate Employer contributions toward such insurance.

**14.10 Inability to Locate Payee**

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

**14.11 Effect of Mistake**

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

## ARTICLE XV. General Provisions

### 15.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 with respect to Health FSA Benefits and Section 8.6 with respect to DCAP Benefits, and then by the Employer. For HSA Benefits, a separate HSA trustee/custodial fee may be assessed by the Participant's' HSA trustee/custodian.

### 15.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

### 15.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

### 15.4 Governing Law

This Plan shall be construed, administered, and enforced according to the laws of the State of Delaware, to the extent not superseded by the Code, ERISA, or any other federal law.

### 15.5 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code, and of all regulations issued thereunder. The Health FSA Component is intended to comply with all applicable requirements of ERISA and of all regulations issued thereunder This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and such applicable law(s), the provisions of which shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

**15.6 No Guarantee of Tax Consequences**

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

**15.7 Indemnification of Employer**

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

**15.8 Non-Assignability of Rights**

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

**15.9 Headings**

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

**15.10 Plan Provisions Controlling**

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

**15.11 Severability**

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

* * *

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the BAYADA Home Health Care, Inc. Cafeteria Plan, BAYADA Home Health Care, Inc. has caused this Plan to be executed in its name and on its behalf.

**BAYADA Home Health Care, Inc.**

By: Brian Pressler ______________________________ Date: May 31, 2023 ____________________

Its Authorized Representative

## APPENDIX A

The following Related Employers have adopted the Plan:

- Tri-County Home & Hospice Care, LLC, 47-5652668
- BBKSHH LLC, 82-0884867
- BPS Philadelphia, LLC, 81-4397563
- SCHHA LLC, 23-1943113
- UBMHHA LLC, 23-1943113
- BAYBAP LLC, 85-3852455
- VCU Health at Home by Bayada, 86-3752407
- Oasis Home Health, LLC, 20-0008008
- Jeffhome PA, LLC, 87-4032379
- Jeffhome NJ, LLC, 87-4025809
- Bayada Hearts for Home Care, Inc., 87-1290656
- UB of West FL, LLC, 85-1684270
- Integrity Home Care, LLC, 43-1875357
- Integrity Hospice of Kansas City, LLC, 47-2283024
- Integrity Home Care of Kansas, LLC, 83-3422665

This Appendix A is effective as of January 1, 2023. This Appendix may be updated at any time without the need for a formal plan amendment.