# AGENDA
## MEETING OF THE
## EL CAMINO HEALTHCARE DISTRICT BOARD OF DIRECTORS

**Tuesday, February 10, 2026 – 5:30 pm**

El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT:

**1-669-900-9128, MEETING CODE: 948 7650 2794#. No participant code. Just press #.**

To watch the meeting, please visit:

ECHD Meeting Link

Please note that the livestream is for **meeting viewing only** and there is a slight delay; to provide public comment, please use the phone number listed above.

**NOTE**: In the event that there are technical problems or disruptions that prevent remote public participation, the Chair has the discretion to continue the meeting without remote public participation options, provided that no Board member is participating in the meeting via teleconference.

A copy of the agenda for the Special Board Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at **(650) 988-3218** prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

| | AGENDA ITEM | PRESENTED BY | ACTION | ESTIMATED TIMES |
|---|---|---|---|---|
| **1.** | **CALL TO ORDER/ROLL CALL** | John Zoglin, Board Chair | Information | **5:30** |
| **2.** | **SALUTE TO THE FLAG** | John Zoglin, Board Chair | Information | **5:30** |
| **3.** | **POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | John Zoglin, Board Chair | Information | **5:30** |
| **4.** | **PUBLIC COMMUNICATION**<br>a. Oral Comments<br>*This opportunity is provided for persons desiring to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.*<br>b. Written Public Comments<br>*Comments may be submitted by mail to the El Camino Hospital District Board of Directors at 2500 Grant Road, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted to the agenda.* | John Zoglin, Board Chair | Information | **5:30** |
| **5.** | **COMMUNITY BENEFIT SPOTLIGHT: SOUTH ASIAN HEART CENTER**<br><br>Adopt Resolution 2026-01 | Jon Cowan, Executive Director, Government Relations and Community Partnerships<br>Ashish Mathur. Executive Director, South Asian Heart Center | **Motion Required** | **5:30 – 5:45** |
| **6.** | **ECHD TERM LIMITS DISCUSSION** | Julia Miller, Secretary/Treasurer<br>Theresa Fuentes, CLO | **Possible Motion** | **5:45 – 5:55** |

| | AGENDA ITEM | PRESENTED BY | ACTION | ESTIMATED TIMES |
|---|---|---|---|---|
| **7.** | **ECHD STRATEGY** | John Zoglin, Board Chair<br>Dan Woods, CEO | **Possible Motion** | **5:55 – 6:10** |
| **8.** | **WORKFORCE HOUSING ASSESSMENT** | Ken King, CASO | Discussion | **6:10 – 6:30** |
| **9.** | **POPULATION HEALTH STRATEGY DIALOGUE: SCOPE, APPROACH & OBJECTIVES, KPIs** | Dan Woods, CEO<br>Jon Cowan, Executive Director, Government Relations and Community Partnerships | Discussion | **6:30 – 6:45** |
| **10.** | **FY27 ECHB DIRECTOR REAPPOINTMENT AD HOC COMMITTEE UPDATE** | Carol Somersille, M.D., Ad Hoc Committee Chair<br>Theresa Fuentes, CLO | Discussion | **6:45 – 6:55** |
| **11.** | **RECEIVE ECHD FY26 FINANCIAL REPORT**<br>- FY26 Period 6 | Raju Iyer, CFO<br>Michael Walsh, Controller | **Motion Required** | **6:55 – 7:05** |
| **12.** | **RECESS TO CLOSED SESSION** | John Zoglin, Board Chair | **Motion Required** | **7:05 – 7:06** |
| **13.** | **DISCUSSION WITH LEGAL COUNSEL**<br>*Report involving Gov't Code Section 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation:*<br>*- Discussion with Legal Counsel* | Theresa Fuentes, CLO<br>Michael Walsh, Controller | Discussion | **7:06 – 7:26** |
| **14.** | **APPROVE MINUTES OF THE CLOSED SESSIONS OF THE DISTRICT BOARD MEETINGS**<br>a. Minutes of the Closed Session of the District Board Meeting (11/08/2025)<br>b. Minutes of the Closed Session of the District Board Meeting (12/10/2025)<br>*Report involving Gov't Code Section 54957.2 for closed session minutes.* | John Zoglin, Board Chair | **Motion Required** | **7:26 – 7:28** |
| **15.** | **EXECUTIVE SESSION**<br>*Report involving Gov't Code Section 54957 for discussion and report on personnel performance matters – CEO* | John Zoglin, Board Chair | Discussion | **7:28 – 7:35** |
| **16.** | **RECONVENE OPEN SESSION** | John Zoglin, Board Chair | **Motion Required** | **7:35 – 7:36** |
| **17.** | **CLOSED SESSION REPORT OUT** | Gabe Fernandez, Governance Services Coordinator | Information | **7:36 – 7:37** |

| | AGENDA ITEM | PRESENTED BY | ACTION | ESTIMATED TIMES |
|---|---|---|---|---|
| **18.** | **CONSENT CALENDAR**<br>*Items removed from the Consent Calendar will be considered separately.*<br>a. Approve Minutes of the Open Session of the District Board Meeting (11/08/2025)<br>b. Approve Minutes of the Open Session of the District Board Meeting (12/10/2025)<br>c. Approve Minutes of the Open Session of the District Board Site Visit Meeting (12/12/2025)<br>d. Approve ECHD Resolution 2026-02 - ECHD Formal Record of Action Adopting the El Camino Hospital Health and Welfare Plan ("Plan")<br>e. Receive ECHD Sponsorships (December – January)<br>f. Receive FY26 Pacing Plan | John Zoglin, Board Chair | **Motion Required** | **7:37 – 7:40** |
| **19.** | **ECHD SITE VISIT CADENCE** | John Zoglin, Board Chair<br>Jon Cowan, Executive Director, Government Relations and Community Partnerships | Discussion | **7:40 – 7:45** |
| **20.** | **BOARD ANNOUNCEMENTS** | John Zoglin, Board Chair | Information | **7:45 – 7:50** |
| **21.** | **ADJOURNMENT**<br><br>**Appendix** | John Zoglin, Board Chair | **Motion Required** | **7:50 pm** |

**Next Meetings**: March 10, 2026; May 19, 2026; June 23, 2026

**Next Site Visit Meetings**: March 20, 2026

# EL CAMINO HEALTHCARE DISTRICT

RESOLUTION 2026 - 01

## RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HEALTHCARE DISTRICT REGARDING RECOGNITION OF SERVICE TO THE COMMUNITY

**WHEREAS,** the Board of Directors of the El Camino Healthcare District values and wishes to recognize the contribution of individuals who serve the District's community as well as individuals who exemplify the El Camino Healthcare District's mission and values; and

**WHEREAS,** the Board wishes to honor and recognize South Asian Heart Center for its leadership in addressing cardiovascular disease within South Asian communities through culturally responsive education, research, and prevention efforts; and

**WHEREAS,** South Asian populations experience a disproportionate burden of heart disease, often at younger ages and with unique risk factors that require tailored approaches to care and prevention; and

**WHEREAS,** the South Asian Heart Center has demonstrated a sustained commitment to health equity by improving awareness, early detection, and prevention of heart disease through community engagement and evidence-based programs; and

**WHEREAS,** the Board acknowledges South Asian Heart Center for its meaningful contributions to community health and its dedication to advancing cardiovascular wellness.

**NOW THEREFORE BE IT RESOLVED** that the Board does formally and unanimously pay tribute to:

South Asian Heart Center

**IN WITNESS THEREOF,** I have here unto set my hand this **10TH DAY OF FEBRUARY, 2026.**

**EL CAMINO HEALTHCARE DISTRICT BOARD OF DIRECTORS:**

Peter C. Fung, MD • Julia E. Miller • Carol A. Somersille, MD • George O. Ting, MD • John L. Zoglin

**JULIA E. MILLER**
**SECRETARY/TREASURER**
**EL CAMINO HEALTHCARE DISTRICT BOARD OF DIRECTORS**

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Julia Miller, El Camino Healthcare District Director
Theresa Fuentes, Chief Legal Officer
**Date:** February 10, 2026
**Subject:** District Board Term Limits

**Purpose**: Possible motion to:

(a) request staff prepare a resolution and ballot measure adopting term limits for District Board members that shall take effect prospectively starting with the **November 2026** election, and based on preference of the board, the term limits shall be either three four-year terms, for a total of 12 years, or four four-year terms, for a total of 16 years;

**or**

(b) request staff prepare a resolution and ballot measure adopting term limits for District Board members that shall take effect prospectively starting with the **November 2028** election, and based on preference of the board, the term limits shall be either three four-year terms for a total of 12 years, or four four-year terms, for a total of 16 years;

**or**

(c) request staff to engage in public outreach to get input from the public on the question of term limits for the District Board and bring back to the board for consideration at a future meeting.

**November 18, 2025 Board meeting.** Potential District Board term limits were brought to the District Board for discussion in November 2025. The board members expressed mixed feelings with some board members leaning against adopting term limits for various stated reasons, including the need for a stable and experienced board, the complexities of serving on the board, the limited pool of candidates, achieving accountability through elections, and existing term limits on the hospital board for community members.

The board requested that the matter be brought back in February for further discussion and a potential vote, with the option for 12-year term limit, or 16-year term limit. Following the November board meeting, we received information from the County regarding the estimated costs to put term limits on the ballot in November 2026, which is summarized below. We are also including the summary and materials provided at the November meeting for ease of reference.

**Summary:** All District Board members currently serve on the El Camino Hospital Board, along with other appointed directors. The Hospital Board imposes term limits of 12 years on its appointed directors, and recent discussions arising out of the Hospital Board assessment and Bylaws revision suggested that the District Board review whether term limits should apply to the District Board.

## Legal Authority

Health and Safety Code § 32100 sets a standard four-year term for healthcare district directors but does not place any limits on consecutive terms. Government Code § 53077 permits the governing body of a district to adopt a resolution to limit the number of terms that a district board member may serve with a majority vote by the electorate. Specifically, this provision states:

(a) Notwithstanding any other provision of law, the governing body of a district may adopt or the residents of a district may propose, by initiative, a proposal to limit or repeal a

limit on the number of terms a member of the governing body of the district may serve on the governing body of the district. Any proposal to limit the number of terms a member of the governing body of the district may serve on the governing body of the district shall apply prospectively and shall not become operative unless it is submitted to the electors of the district at a regularly scheduled election and a majority of the votes cast on the question favor the adoption of the proposal.

(b) For purposes of this section, the term "district" shall mean an agency of the state, formed pursuant to general law or special act, for the performance of governmental or proprietary functions within limited boundaries.

**Examples from Local Public Agencies**

We are not aware of any healthcare districts that have imposed term limits on their board members. As such, we compiled examples from local cities and special districts (non-healthcare) that have imposed term limits on their board members, including through ballot measures. This summary is included in Attachment A.

- Santa Clara Valley Water District – Measure A (2022): Extended term limits from three to four consecutive four-year terms.
- South Bay Union School District – Measure X (2020): Established a lifetime limit of three elected terms (partial terms not counted).
- Los Altos – Measure G (1999): Adopted two consecutive four-year term limits.
- Sunnyvale – Measure B (2020): Amended the City Charter to set a three-term limit (four years per term) within a 16-year period, requiring a four-year break before re-eligibility.
- Mountain View – Charter Amendment (2023): Reinforced two term limit (four years per term).
- Los Gatos - Measure B (2020): Adopted two consecutive four-year term limits. After serving two consecutive terms, a member must wait at least four years before being eligible to serve again.

**Publications Regarding Pros and Cons of Term Limits**

For informational purposes, several publications discuss the pros and cons of term limits for board members of public entities. These publications are itemized in Exhibit B. In general, the pros and cons discussed in these publications include:

**Pros of Term Limits**

- **Board Renewal:** Ensures regular turnover, bringing in new members and fresh perspectives.
- **Increased Diversity:** Provides opportunities for a wider range of backgrounds, skills, and viewpoints.
- **Prevention of Entrenchment:** Limits the risk of individuals holding power for too long, reducing stagnation and dominance.
- **Enhanced Accountability:** Promotes responsiveness to the public or stakeholders.
- **Encourages Broader Participation:** Opens the door for more people to serve, fostering civic engagement.

**Cons of Term Limits**

- **Loss of Institutional Knowledge:** Experienced members leave, resulting in diminished historical perspective and expertise.
- **Reduced Expertise:** Frequent turnover can lead to less experienced leadership and weaker policy outcomes.

- **Disruption of Continuity:** Ongoing projects and initiatives may be interrupted or lose momentum.
- **Increased Turnover:** Creates a constant need for onboarding and training new members, which can strain resources.
- **Potential for Short-Term Focus:** Members may prioritize immediate results over long-term planning due to limited time in office.

## Costs of Ballot Measure to Impose Term Limits

The County of Santa Clara advises that the cost to the District to place a term limit measure on the ballot along with board member elections in November 2026 will be approximately $737,697.00 ($522,884 for governing board seats, plus $214, 813 for first measure). This does not include the estimated cost per candidate statement. The estimates are based on projected registration and available information and are subject to change pending the final billing of actual charges after the election.

## Next Steps

If the board votes in favor of term limits, staff will work with the Board Chair to prepare a resolution and draft ballot language and present it to the board at an upcoming meeting.

## Attachments:

1. Examples of City and Special District Term Limits (October 2025)
2. Examples of Publications re Term Limits for Public Entities

**ATTACHMENT A**

**EXAMPLES of City and Special Districts**
**Term Limits on Council and Board Members**

---

## Mountain View

In Mountain View, City Councilmembers can serve a maximum of two consecutive four-year terms. Most board and commission members also serve four-year terms, but term limits are not specified by the same municipal code that limits the council. In 2023, the city amended the term limits for the mayor.

City Council term limits

- **Term length:** Four years.
- **Limit:** Councilmembers are limited to two consecutive full terms.
- **Mayor:** An amendment to the City Charter, effective November 7, 2023, limits the Mayor to three four-year terms. A person appointed to the position for less than a year to fill a vacancy does not have that time counted toward the limit.
- **Staggered terms:** Elections are staggered, with three or four council seats open every two years.

Boards and commissions term limits

- **Term length:** Members of most boards and commissions serve four-year terms, with the exception of the Downtown Committee, whose members serve three-year terms.
- **Limit:** The city's website for boards, commissions, and committees does not specify any term limits for these volunteer positions. Members are appointed by the City Council.

Local measures

The term limits were established by amendments to the Mountain View City Charter rather than specific ballot measures named for term limits

- **2023 Charter Amendment:** The limit for the mayoral term was established by a Charter election on November 7, 2023

City Election Information

The City of Mountain View is a Charter city with a Council-Manager form of government. Seven Councilmembers are elected at-large by City voters in November of even-numbered years. Each Councilmember may serve a maximum of two consecutive four-year terms.

The next General Municipal Election will be held on November 3, 2026

---

## Sunnyvale

Sunnyvale voters passed Measure B in March 2020, establishing term limits for the City Council.

- **Maximum Service:** Council members can serve a maximum of three consecutive four-year terms within any sixteen-year period.
- **"Cooling-off" Period:** After reaching the three-term limit, a person must wait at least four years before being eligible to serve on the council again.

## MEASURE B

### IMPARTIAL ANALYSIS
### PREPARED BY THE SUNNYVALE CITY ATTORNEY

The City Council placed Measure B on the ballot to ask voters if the City Charter should be amended to change how the City elects councilmembers.

Historically, Sunnyvale's seven City councilmembers have been elected in an 'at-large with numbered seats' system, meaning each is elected to a specific seat by the voters of the entire City and can live anywhere in the City. The Council selects one of its members to serve as Mayor for a two-year term.

Agencies throughout California with at-large election systems have been increasingly threatened with lawsuits under the California Voting Rights Act ('CVRA') claiming at-large systems illegally dilute minority votes, and impair the ability of minority groups to elect candidates of their choice because of racially polarized voting. In September 2018, the Council reviewed the legal risk from the CVRA and initiated a public process for input on transitioning to district-based elections to avoid potential C VRA issues. In October 2018, the City received a Notice of C VRA Violation from potential plaintiffs alleging the City's at-large system dilutes the voting strength of Asian American voters. After months of City outreach and public input on the change and establishing district boundaries, the Council placed Measure B on the ballot.

Measure B proposes three key changes to Charter Article VI:

(1) Six city council districts. Measure B would establish six City Council electoral districts. Voters of each district would elect one councilmember who must live in that district. The Council adopted an ordinance establishing the district boundaries that will become effective if Measure B passes.

(2) Mayor directly elected. Measure B would establish a directly elected Mayor with a four- year term. The Mayor could live anywhere in the City and all voters would vote for the Mayor regardless of where they live.

(3) Increase total term limits. Currently, City councilmembers may not serve more than two consecutive four-year terms.

Measure B would allow members to serve up to three consecutive four-year terms, with no more than two terms as council member or mayor. A 'YES' vote means you want to change the City's electoral system from 'at-large with seven numbered seats' to 'by-district' with six councilmember districts and a directly elected Mayor. Three districts and the Mayor office will be on the November 2020 ballot. Current councilmembers with time remaining in office will continue to serve until they complete their respective terms. The other three districts will be on the 2022 ballot.

A 'NO' vote means you want the City to retain its at-large with numbered seats electoral system with the Mayor selected by the Council.

**BALLOT QUESTION**

Shall Article VI of the City of Sunnyvale Charter be amended to establish "by-district" elections for six Council members required to be residents of a district and elected only by the voters of that district, and one Mayor who will be directly elected by all City voters; change term limits to permit service on the Council for three consecutive terms but only two as Council member or Mayor; and make other conforming amendments?

---

**Los Altos**

Los Altos has existing term limits for its City Council, which were approved by voters in 1999 (Measure G).

- **Maximum Service:** Council members are limited to serving no more than two consecutive four-year terms.
- **Consecutive, not Cumulative:** The limit is for consecutive terms, meaning a person can serve another two terms after a break in service.
- **Recent Activity:** In February 2025, the Los Altos City Council considered a charter amendment to change the term limits but decided not to place a measure on the ballot at that time. Any change to the term limits would require voter approval.

---

**Cupertino**

There are no term limits for Cupertino City Council members, who are elected at-large to four-year terms.

---

**Los Gatos**

Town Council members are limited to serving no more than two consecutive four-year terms. After serving two consecutive terms, a member must wait at least four years before being eligible to serve on the Council again. This term limit was established by voters through the approval of Measure B in November 2020.

Prior to the passage of Measure B, there were no term limits for the Town Council. Council members are elected "at large" (representing the entire community) for staggered four-year terms.

**MEASURE B**

**TOWN ATTORNEY'S IMPARTIAL ANALYSIS**

The Los Gatos Town Council consists of five members, each elected by the voters to serve for a four-year term. The Town does not currently impose term limits on its Town Council Members.

Measure "B" proposes the adoption of an Ordinance which would establish term limits for Town Council Members as set forth below.

If Measure "B" is approved, no person who has served two consecutive four-year terms on the Town Council will be permitted to seek nomination or election for a new term until he or she has stayed off the Council for at least four years after the expiration of his or her second consecutive term. Partial terms (two years or less) to fill Council vacancies will not count against the term limit. Therefore, someone who has served a prior partial term of two years or less could still serve two consecutive four-year terms. However, a person could not serve two consecutive four-year terms and then serve a partial term unless and until four years have passed from the end of the person's two consecutive full four-year terms and the beginning of the partial term. Any member of the Town Council who leaves office during a term shall be deemed to have served the entirety of their term.

If Measure "B" is approved, it would apply prospectively to all future four-year Town Council terms starting with those elected at the November 3, 2020 election.

A “yes” vote on Measure “B” will authorize the term limits on Town Council service as set forth above.

A "no" vote on Measure "B" will not authorize the term limits on Town Council service as set forth above.

Measure "B" will be approved if it receives a simple majority of "Yes" votes.

**BALLOT QUESTION**

Shall the measure proposing a term limit ordinance to require that after serving two (2) four (4) year terms, a Town Council Member is not eligible to run for the Town Council or to be appointed to a vacancy unless a period of four years has elapsed since their last service on Town Council, be adopted?

---

**La Palma (Orange County)**

In the November 2024 general election, La Palma voters passed Measure W, which increased the term limits for city council members. The new rules allow members to serve up to three consecutive four-year terms, followed by a mandatory four-year break. This replaced the previous limit of two consecutive four-year terms.

Details on the term limit change

- **Previous limit**: Two consecutive four-year terms, for a total of eight years.
- **New limit (Measure W)**: Three consecutive four-year terms, for a total of twelve years.
- **Post-service rules**: Following their consecutive terms, a council member must be out of office for at least four years before they are eligible to run again.

## MEASURE W

**Background**

In the last 5 years, the City of La Palma has consistently made strides to change how representatives are elected to serve as city council members. In 2022, the City shifted its council elections from at-large to by-district elections in which each council member represents a different geographic area of La Palma. November 2024 will be the first election in which some members of the council are elected from districts. With the shift to by-district elections, the City is now looking to reform term limits, initially adopted in 1982, to further adapt to the by-district elections model.

The City Council has placed Measure W on the November 2024 General Election ballot to seek additional reforms to how council members represent residents. The reforms seek to update the term limits to be three consecutive terms on the City Council with a four-year out-of-office period before the clock resets on serving on the City Council.

In advancing this item for consideration by voters, the City Council noted the reasons for consideration:

- La Palma's districts are quite small and the pool of candidates is small as well. There are concerns that a reduced candidate pool could leave voters with few choices on the ballot.
- Regional politics and Sacramento continue to impact local residents, and the City's influence could be enhanced with council members who have time and seniority among regional leaders to gain critical positions on the regional board and protect La Palma. For example, the next process to require more housing units in La Palma could be assisted if the City can place an elected leader on the regional governance board to ensure La Palma is not forced to significantly upzone neighborhoods and affect our quality of life. Regional boards also address homelessness, transportation projects and regional fund allocations for investments in local projects.
- This update preserves term limits while balancing the realities of the new by-district election process.

As La Palma has recently transitioned to district elections to enhance local representation, the City is also reconsidering its term limits to broaden the pool of candidates. This change is partly driven by the need for effective representation in regional organizations that influence local quality of life through policies on homelessness, housing development, and the reinvestment of regional funds into local projects. These regional bodies are often governed by city leaders who have longer durations on their city councils. The La Palma City Council has observed that longer-duration city council members gather more regional relationships and position appointments to help advocate for their city on these regional matters.

Residents will have a chance to vote on this change at the ballot box in November 2024 during the General Election. Since term limits were initially adopted by the voters of La Palma, it is also in the hands of La Palma voters to amend the term limits. The power rests with the voters.

## BALLOT QUESTION

To expand the ability of La Palma voters to choose who is elected to city council; provide the opportunity for more consistent community leadership; and broaden the candidate pool for newly created district elections; shall voters limit city council members to three consecutive terms in

office with a mandatory four year out of office period, which will expire if council elections return to at-large elections?

---

**Long Beach**

In November 2018, Long Beach voters passed Measure BBB, which increased the term limit for the Mayor and City Council members from two to three four-year terms, for a maximum of 12 years.

Changes to term limits under Measure BBB

- **Three-term limit:** Measure BBB allows the Mayor and City Council members to serve a maximum of three four-year terms. Previously, officials were limited to two terms.
- **Elimination of the write-in loophole:** Under the previous term limits, officials could run for additional, unlimited terms as write-in candidates after their two regular terms were complete. Measure BBB eliminated this loophole, making the three-term limit a firm cap on service.
- **Effective date**: The term limits took effect for all service *after* November 6, 2018, meaning that terms served before this date do not count toward the new limit.

**MEASURE BBB**

**IMPARTIAL ANALYSIS**
**PREPARED BY THE OFFICE OF THE LONG BEACH CITY ATTORNEY**

Voter approval of Measure "BBB" would amend Section 214 of the Long Beach City Charter, relating to term limits for the offices of Mayor and City Councilmember.

On August 7, 2018, the Long Beach City Council placed Measure "BBB" on the ballot for the consideration of Long Beach voters. Long Beach City Charter Section 214, "Term Limitations on Ballot Access by Candidates for City Council and Mayor," currently provides that the Mayor and City Councilmembers may serve no more than two terms in office, unless they run as a write-in candidate. The Charter currently provides no limit on the number of times a candidate may run as a write-in, and further provides that the name of the write-in candidate who has been nominated at a primary election shall appear on the ballot for the general election as if he or she were formally nominated (not a write-in candidate).

The proposed measure would provide that during his or her lifetime, a person may serve no more than three terms, as further defined in the measure, as Mayor, and no more than three terms as City Councilmember. From the November 6, 2018, general municipal election and for all future elections, any write-in candidacy will count towards the three-term limit. The proposed measure would further prohibit any candidate for the office of Mayor who has served three terms or City Councilmember who has served three terms from running as a write-in candidate. Under state law, term limits measures may only apply prospectively.

Measure "BBB" requires simple majority approval of Long Beach voters to pass. If Measure "BBB" does not pass, the current Charter term limits will remain in effect.

**BALLOT QUESTION**

Shall the City Charter be amended to limit the Mayor and City Councilmembers to serving three terms and to prohibit individuals who have already served three terms from being elected as write-in candidates?

---

**San Diego Unified School District Board of Education**

The Board of Education for the San Diego Unified School District has a three-term limit, which took effect following the November 2022 election.

Key details of the policy:

- **Effective date**: The term limits began with the elections held in November 2022.
- **Term length**: Each elected term is four years long.
- **Lifetime limit**: The three-term limit applies to a person's entire service on the board, regardless of which trustee area they represent. Once a person has served three full elected terms, they are prohibited from seeking further election or appointment to the board.
- **Partial terms**: A partial term does not count toward the limit. A person who is appointed or elected to fill a vacancy for less than a full term will not have that partial term counted.

The term limit was enacted by the board and approved by voters in Measure H, consistent with California Education Code.

**MEASURE H**

**BALLOT TITLE**

Amendments to San Diego City Charter Section 66 to Enact Term Limits for Members of the Board of Education of the San Diego Unified School District

**BALLOT SUMMARY**
**PREPARED BY THE SAN DIEGO CITY ATTORNEY**

This measure would amend the San Diego City Charter (Charter) to enact term limits for members of the Board of Education of the San Diego Unified School District (School Board).

If approved by voters, Charter section 66 would limit a member of the School Board to serving three four-year terms, beginning in 2020. Those School Board members who hold office on the date of the Municipal General Election in November 2020 would not have their prior or current terms counted for purposes of the new term limit.

The ballot measure was proposed during a process in which members of the public submitted ballot measure proposals for consideration by a Council standing committee and then the full Council. The Council voted to place the measure on the ballot. If approved, the Charter would be amended as of the date the amendments are chaptered by the California Secretary of State.

**BALLOT QUESTION**

Shall City Charter section 66 be amended to limit a member of the San Diego Unified School District Board of Education from serving more than three four-year terms, beginning in 2020, and

not count prior or current terms for purposes of the term limit for those School Board members who hold office on the date of the Municipal General Election in 2020?

---

**Santa Clara Valley Water District**

Voters in Santa Clara County, including those in Sunnyvale, Los Altos, and Cupertino, initially passed term limits in 2010. However, in June 2022, a measure was proposed to extend these term limits.

Details of the Change

- **Before Measure A:** Board members were limited to a maximum of three consecutive four-year terms.
- **After Measure A:** The limit was extended to four consecutive four-year terms.

**MEASURE A**
Ordinance Amendment
Majority Vote

**BALLOT QUESTION**

Shall the measure amending the Santa Clara Valley Water District Ordinance 11-01 to limit Board members to four successive four-year terms be adopted?

---

**South Bay Union School District**

South Bay Union School District voters approved Measure X in November 2020 limiting board members to three elected terms.

Details of the term limit

- **Effective date:** The term limit applies to any board term that began on or after December 1, 2020.
- **Lifetime limit:** The three-term limit is for a lifetime, meaning a person who has served three elected terms cannot run for re-election.
- **Partial terms:** A partial term (when a person is elected or appointed to fill a vacancy) does not count toward the three-term limit.
- **Incumbents:** Board members who were serving when the measure was approved became eligible to serve up to three additional terms.

**MEASURE X (FULL TEXT)**

In 1996 the California State Legislature amended specific Government Code and Education Code sections to permit the governing body of a local public agency, such as a school district, to adopt a proposal to limit the number of terms a member of the governing board may serve and to submit that term limit proposal to the electors.

The South Bay Union School District ('District') Board of Trustees ('Board') believes that:

a) Full and free access to elected offices is a right of all citizens;

b) Unchecked multiple terms of incumbency allows the entrenchment of politicians creating an inequitable advantage in the electoral process;

c) Ensuring equal access to the elected positions of the District is a critical public benefit and will reduce the cost of running for this important public office and remove the inherent advantage of incumbency allowing increased public participation in the electoral process;

d) Setting a limit on the number of terms an individual may serve on the Board will cause a rejuvenation of the Board by bringing fresh ideas and broadening the range of persons making important decisions effecting the District, its students and schools and will create more competitive elections by ensuring that periodically the advantages of incumbency of a Board member will yield to increase citizen participation in seeking elective office.

**TERM LIMIT PROPOSAL**

Pursuant to Education Code Section 35107, and the findings above, the Board adopted the following proposal to limit the number of terms a member of the Board may serve ('Proposal') on December 19, 2019. This Proposal, if approved, by a majority of the votes cast by the registered voters residing within the boundaries of the District and voting thereon will prohibit an individual from serving more than three (3) elected terms on the Board as follows:

No person may serve for more than three elected terms as a Board member, regardless of trustee area represented. No person who has served for three terms as a Board member may seek election or appointment for additional service as a Board member.

Any person who serves a partial term as a Board member by way of appointment, election, resignation, removal from office, or any combination thereof, shall not be deemed to have served a full term.

The limitation on the number of terms shall apply only to terms that begin on or after December 1, 2020

The limits imposed by this Proposal may only be amended or repealed pursuant to the requirements of the Education Code.

**BALLOT QUESTION**

Shall the Members of the South Bay Union School District Board of Trustees be limited to three (3) elected terms of office?

# ATTACHMENT B

# Example Literature on Term Limits for Board Members of Public Entities

## National League of Cities (NLC)

**Title:** Cities 101 — Term Lengths and Limits
**Link:** https://www.nlc.org/resource/cities-101-term-lenths-and-limits/
**Summary:** This resource provides an overview of how term lengths and term limits are structured for city council members across the United States. It explains the rationale behind implementing term limits, such as promoting fresh perspectives and preventing entrenchment. The article also discusses the benefits (e.g., increased accountability, regular infusion of new ideas) and drawbacks (e.g., loss of experienced leaders, disruption of continuity) associated with term limits for local elected officials.

## 2. BoardSource

**Title:** Terms and Term Limits
**Link:** https://boardsource.org/resources/term-limits/
**Summary:** BoardSource's article examines the advantages and disadvantages of imposing term limits on board members. It highlights how term limits can foster board renewal and diversity, but may also result in the loss of valuable institutional knowledge. The resource provides practical advice for boards considering term limits, including recommendations for balancing continuity with the need for new perspectives.

## 3. Public Policy Institute of California (PPIC)

**Title:** Adapting to Term Limits: Recent Experiences and New Directions
**Authors:** Bruce E. Cain, Thad Kousser, Karl E. Kurtz
**Link:** https://www.ppic.org/wp-content/uploads/content/pubs/report/R_1104BCR.pdf
**Summary:** This report analyzes the impact of term limits on legislative bodies, with findings relevant to public boards. The authors discuss how term limits can lead to reduced expertise among members, increased turnover, and shifts in policy outcomes. The report also explores strategies for adapting to these changes, such as improving onboarding and training for new members to mitigate the loss of institutional knowledge.

# EL CAMINO HEALTHCARE DISTRICT
# BOARD MEETING COVER MEMO

**To:** El Camino Healthcare District Board of Directors
**From:** John Zoglin, Board Chair
Dan Woods, Chief Executive Officer
**Date:** February 10, 2026
**Subject:** El Camino Healthcare District Strategy

**Purpose:** To solicit feedback from the Board of Directors on a strategic planning process for the El Camino Healthcare District (ECHD).

**Summary:**

- In FY2023, the District Board adopted a Strategic Framework which grew out of an initial discussion of District goals. Board members provided feedback on February 8, 2023, March 28, 2023, and May 16, 2023, before the Strategic Framework was adopted in June 2023.
- The Strategic Framework continues to guide the work of the District's Community Benefit Program, including the Population Health Strategy and its initial focus on prediabetes.
- There is board member interest in a broader strategic planning process, including the potential revision of the current mission, and vision, and further development of values, key performance indicators, and targets for ECHD.

Management proposes development of a ECHD strategic plan with the following objectives:

- Assessing the most relevant trends in Healthcare Districts and how they apply to ECHD
- Review, refine (or define as needed) and adopt a mission, vision, values, key performance indicators and targets for ECHD
- Alignment on the best structure for delivery of programs and services by the District
- El Camino Healthcare District's role in providing value to taxpayers
- How to leverage innovation capabilities to better serve constituents
- Identifying areas for differentiating ECHD services and ensuring healthcare access

The Strategy development process would culminate in a final report which includes:

  - Suggested ideal mission, vision, values, KPIs, and targets for ECHD's programs and services
  - Organizational structures and approach for partnering with El Camino Health system and other community entities (e.g., Santa Clara County, Other Healthcare Districts, corporations, etc.) to enhance care delivery in a cost effective manner
  - Key steps and resource requirements over the next 5 years to implement these strategies

- To accelerate the development process, management has already issued an RFP to identify potential external consultants (strategic advisors). This allows the Board to quickly assess how to best support this work in combination with internal resources. Objectives, approach for executing the strategic planning process, use of external vs. internal resources, and timeline can all be adjusted based on feedback this evening.

Outcomes: Management and the advisors would report to the Board regularly to provide updates on assessment and recommendations. Management will support the strategic planning process, under the direction and feedback from the board. The rapid timeline designed to complete work this fiscal year is presented below for feedback as well. The timeline will be developed further as we receive responses from potential strategic advisors.

| **EVENT (Current Estimate – subject to change)** | | **DATE** |
|---|---|---|
| RFP Issue Date | | Friday, January 30, 2026 |
| Last day for Respondents to submit questions and/or requests for clarification | | Friday, February 06, 2026 |
| ECHD's response to questions and/or requests for clarification | | Tuesday, February 10, 2026 |
| Deadline for Respondent's Submission of Written Responses | | Friday, February 13, 2026 |
| Evaluation of Written Responses | | February 16 to 20, 2026 |
| Oral Presentations/Interviews (By Invitation Only) | | Likely week of March 9, 2026 |
| Approximate Award of Contract Date | | Friday, March 20, 2026 |
| Approximate Engagement Start Date | | April 1, 2026 |
| ***Preliminary*** *– Subject to Change* | *Potential Special District Board Meeting – review findings from Assessment* | *Mid-April* |
| | *Potential Special District Board Meeting – Working Session* | *Beginning of May* |
| | *District Board Meeting – Review draft plan* | *May 19, 2026* |
| | *District Board Meeting – Final Review* | *June 23, 2026* |
| Approximate Engagement End Date | | June 30, 2026 |

**List of Attachments:**

**1.** ECHD Strategic Framework (top portion showing adopted Vision and Goal as well as Strategic Priorities, adopted June 2023)

# Strategic Framework

| Vision and Goal | | |
|---|---|---|
| Improve the health & well-being of those in the healthcare district by supporting health promotion, disease prevention, and a healthy lifestyle | | |
| **Strategic Priorities** | | |
| **Access to Healthcare** | **Community Champion** | **Health promotion and disease prevention** |
| Ensure access to high-quality healthcare at the hospital, outpatient clinics, schools, and other sites | Create connection opportunities for local organizations, community groups, and healthcare providers | Promote health and well-being in order to reduce the incidence of chronic illnesses in the community |

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Ken King, CAO
Deanna Dudley, CHRO
**Date:** February 10, 2026
**Subject:** Workforce Housing Assessment

**Purpose:**

The purpose of this item is to inform the Board Members of the Workforce Housing Assessment process and to confirm that the process is in alignment with the Board's expectations.

**Summary:**

In response to Board Members' inquiries regarding the need for Workforce Housing we have engaged a qualified real estate consulting team to perform a full and comprehensive assessment of the need for Workforce Housing. The cost of the assessment services is $68,000.

The presentation is to inform the Board Members regarding the process for the Workforce Housing assessment. No action is requested at this time.

**List of Attachments:**

1. Power Point Presentation - Workforce Housing Assessment – Update

# Workforce Housing Assessment - Update

Ken King, CAO

February 10, 2026

# Workforce Housing Definition

# Most Common Housing Labels

- **Low-Income Housing**
- **Target Audience:** The lowest-income households, often at or below 50% of the Area Median Income (AMI).
- **Purpose:** To provide housing for those most vulnerable to housing instability, often relying on federal programs like Housing Choice Vouchers (Section 8).
- **Affordable Housing**
- **Target Audience:** A broad category for those paying no more than 30% of their gross income on housing, including utilities.
- **Income Range:** Typically covers low-income (under 50-60% AMI) and moderate-income (up to 80% AMI) households.
- **Key Feature:** It's defined by cost burden, not just income, and includes various income levels.
- **Workforce Housing (or Middle-Income Housing)**
- **Target Audience:** Middle-income essential workers (e.g., teachers, police, healthcare workers) who don't qualify for subsidies but can't afford market-rate housing.
- **Income Range:** Generally 60% to 120% of AMI.
- **Purpose:** Fills the "missing middle" gap, ensuring vital community members can live near where they work.

# Comparison Table

## Key Differences Summarized

**Income Focus:** Low-income targets the bottom; workforce targets the middle; affordable encompasses both, defined by a 30% cost-to-income ratio.

**Employment:** Workforce housing specifically implies gainful employment, while affordable housing can serve anyone meeting income/cost criteria, including seniors or people with disabilities.

**Overlap:** Workforce housing is a segment *within* the broader affordable housing spectrum, addressing a specific income bracket often overlooked by traditional affordable programs.

| Feature | Low-Income Housing | Affordable Housing | Workforce Housing |
|---|---|---|---|
| **Primary Target** | Those with very low or extremely low earnings. | A broad category for anyone spending <30% of income on housing. | Gainfully employed "middle-income" workers. |
| **Typical AMI Range** | 0% – 60% (often lower). | Generally 0% – 80% in policy contexts. | 60% – 120% (can reach 150%+). |
| **Common Occupations** | Seniors, persons with disabilities, or unemployed. | Service workers, retail, entry-level roles. | Teachers, police, nurses, first responders. |
| **Funding/Subsidies** | Federal programs like Section 8 or Public Housing. | LIHTC (Tax Credits) and local government grants. | Often unsubsidized; relies on tax incentives or private investment. |

# Assessment Partner & Process

# Volz Company – A Qualified Real Estate Advisory Firm

VOLZ COMPANY

**300+**

Mission-driven organizations that have worked with Volz Company professionals

Founded in 2015 in Irvine, California, Volz Company is a real estate and operational advisory and program management firm. We are organized to serve mission-driven organizations, not-for-profit organizations, higher education institutions, and the development industry on the advancement of their strategic real estate, operational, and business plan objectives. Our services are holistic in nature and purposely intended to suit the specific needs of our clients to achieve their measurements of success.

# Volz Company Client List (Partial)

- **Foothill-De Anza Community College District -** Advisory services for workforce and student housing development, including market and demand analysis, site evaluation/assessment, financial analysis, LOI and PSA negotiations.
- **Napa Valley College -** Faculty/Staff and Student Housing Feasibility Planning, Market and Demand Analysis, Financial Analysis, Project Management and 24/7 Campus Transition Advisory Services
- **Los Angeles Unified School District -** Advisory services for workforce housing development, including market and demand analysis, site evaluation/assessment, financial analysis, and developer procurement
- **San Bernardino Community College District -** Advisory services for workforce and student housing development, including market and demand analysis, site evaluation/assessment, financial analysis, P3 procurement and negotiations, and project management.
- **University of California, Santa Barbara -** Ocean Road P3 Faculty and Staff Rental Housing Analysis
- **California Polytechnic State University San Luis Obispo -** Grand Avenue Faculty and Staff Housing Proposal Leadership, P3 Advisory for University Engagement
- **Pflugerville Independent School District -** Advisory services for P3 teacher housing development, including market and demand analysis, site evaluation, and rent tolerance analysis
- **Louisiana State University Health Sciences Center New Orleans -** Market Share Analysis, Business Case Modeling, and Operational Advisory Services
- **The University of Texas Health Science Center at Houston -** Rental Rate Analysis and Operational Assessment

# Volz Process for Empowered Decision Making


***The Purpose***

Interactive workshop to identify and prioritize desired outcomes throughout the process.

**Market and Demand Analysis**

*Data*

Qualitative and Quantitative Research Findings to include, but not limited to:

- Demand Numbers
- Unit Preferences
- Rent Tolerances

**Financial Analysis**

*Rents and Financial Sustainability*

- Financial models to test assumptions
- Total cost of ownership, Findings

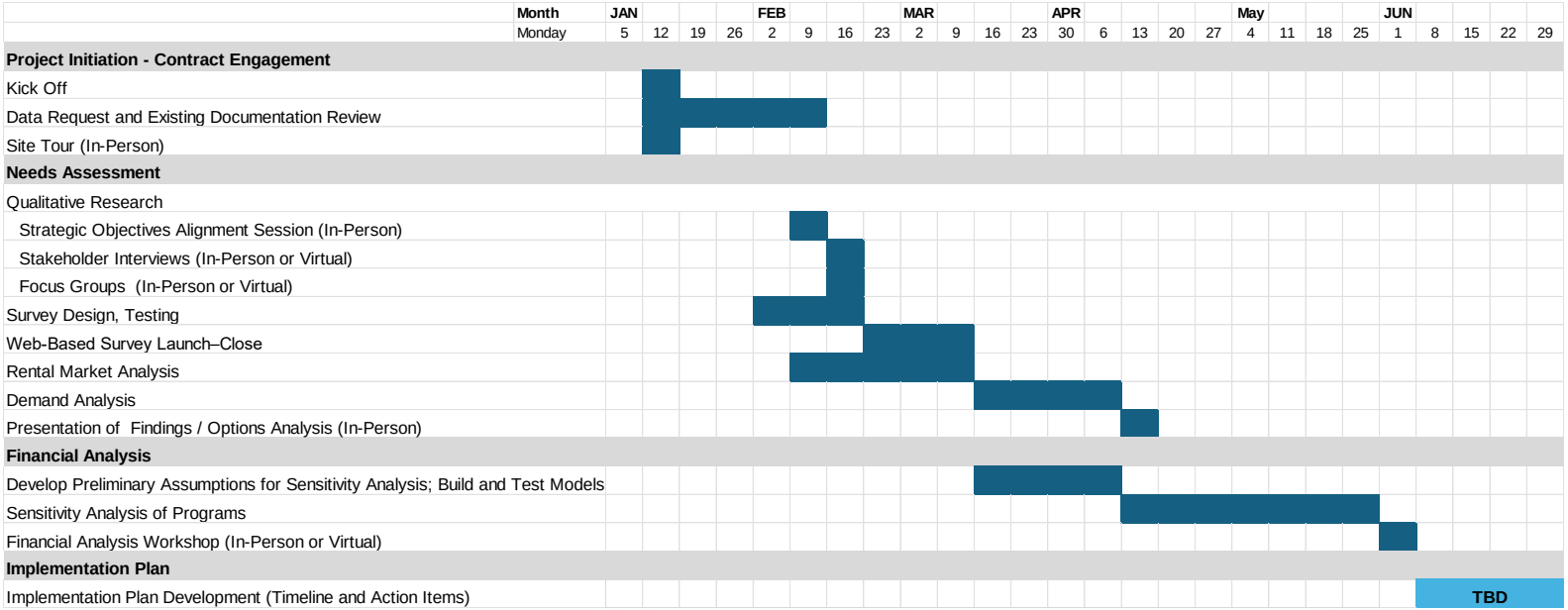
**Site Evaluation**

- Test of sites with a blend of technical and resident experience

**Implementation Plan**

- How and When to Stop, Pause, Proceed

# Process Timeline



# Workforce Housing Feasibility – Data Request

- Total number of current employees by job category (e.g., clinical, administrative, etc.)
- Salary ranges by job category.
- Demographic information on current employees such as age and household composition.
- Employee residential location data, such as home ZIP codes.
- Identification of any existing housing developments or programs that currently serve hospital employees or may compete with potential workforce housing.
- Relevant historical hiring data, including recent trends in new hires and turnover, if available.
- Information on leading reasons for employee attrition, particularly factors related to housing or commute challenges.
- Anticipated changes in recruitment, hiring, or workforce composition over the next few years that could affect housing demand.
- Summary findings or data from any prior employee surveys or studies that address workforce housing, commuting patterns, or related topics, if available.

# ECH Advisory Committee – Workforce Housing

- Tracey Lewis-Taylor, COO
- Deanna Dudley, CHRO
- Theresa Fuentes, CLO
- Ken King, CAO
- Jon Cowan, Exec. Dir. Government Relations & Community Partnerships

# Discussion Items & Questions

- Confirm that direction and approach is acceptable.
- Confirm that the objective is to evaluate the need for Workforce Housing consideration
- Identify any missing key elements.

**Questions?**

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING COVER MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Dan Woods, Chief Executive Officer
Jon Cowan, Executive Director, Government Relations and Community Partnerships
**Date:** February 10, 2026
**Subject:** ECHD Population Health Strategy Dialogue: Scope, Approach & Objectives, KPIs

**Purpose:**

To provide additional context for discussion on the Foundational and Workstream 1 elements of the ECHD Population Health Prediabetes initiative, including additional detail on scope, programming approach & objectives, and KPIs.

**Summary:**

In FY2025, staff developed a Population Health Strategy Roadmap to define the strategic direction for the Prediabetes initiative.

To support the direction and alignment of execution in FY 2026, staff has developed additional materials to connect the 3-5 year strategy to the FY 2026 execution priorities (which were shared at the November District Board Meeting).

The Population Health Prediabetes initiative is unique because ECHD represents a hyperlocal geography and we are taking a broad-based approach to help address individual and social factors in prediabetes risk. The geographic scope enables network effects that more diffuse populations would be unable to achieve, and by taking a broad-based approach, we are able to create a program that can serve all eligible individuals in the District. Further, this approach allows us to support individuals with a spectrum of in-person and social settings, such as healthcare providers, schools, workplaces, community-based organizations, community hubs, and food sources.

To support individuals in the District in better managing prediabetes, we have defined Three Pillars for Meaningful Intervention. The pillars work along a spectrum of behavior change and are rooted in evidence-based theories of behavior change.

**(1) Pillars for Meaningful Intervention**

a. **Awareness:** This pillar is a public-health style campaign intended to highlight prediabetes risk and encourage initial action. The elements include a paid media campaign plus an online risk factor screener.
b. **Action**: This pillar includes offering a tech-forward solution to help people self-manage their own health and prediabetes risk. Season Health, a virtual dietitian / medical nutrition therapy (MNT) program will support individuals in taking further concrete action to implement behavior change.
c. **Sustained Behavior Change**: This pillar will support sustained behavior change through repeat contact with individuals who have engaged with our programs. We will further serve as a convener of in-person services in the District, and act as a health communication partner with information on additional relevant offerings.

**(2) Research & Evidence-based Approach**

a. The pillars are rooted in the Stages of Change Model (or the Transtheoretical Model of Change). Each of the pillars above are connected to a distinct stage of change, as well as a specific tool to be leveraged:

b. **Stages of Change:**
   i. **Precontemplation** (*Pillar*: Awareness; *Tool*: Paid Media Campaign)
   ii. **Contemplation** (*Pillar*: Awareness; *Tool*: Engagement & Outreach)
   iii. **Preparation** (*Pillar*: Action; *Tool*: Navigation & Referrals)
   iv. **Action** (*Pillar*: Action; *Tool*: Season Health & Screening)
   v. **Maintenance** (*Pillar*: Sustained Behavior Change; *Tool*: Ongoing Support & Re-engagement)

**(3) KPIs and Measurement:**

a. Defining goals and measuring success at the District level takes time, particularly given the multi-faceted, broad-based program design. Compared to typical initiatives that are more narrowly focused, our approach expands reach and impact but also requires a baseline year to define metrics and evaluate change credibly over time.

b. In Year 1, program success & measurement will be determined by:
   i. Defining attributable success and the changes we are driving, backed by the Stages of Change model.
   ii. Ensuring metrics are fit for ECHD's role given that many individuals may be in the earlier stages of change and assessing where those metrics require adaptation given ECHD's district-wide scope.
   iii. Establishing credible baselines using data collection, using observed baseline data to measure change, and collecting information on District members (since we aren't relying on a patient relationship).
   iv. Building a scalable measurement infrastructure by confirming who collects what data, when, and how often, and ensuring consistent, reliable reporting with partners.

c. **KPIs**
   i. In addition to overall program success & measurement as defined above, we will also be tracking toward specific engagement-based KPIs in the first 12 months to ensure we are achieving engagement in the interventions we are offering.
   ii. KPIs have been defined based on a review of 15 public health campaigns, peer-reviewed studies, and engagement rates observed in literature and other similar programs.
   iii. **Awareness Pillar:** Number of Prediabetes Risk Screeners:
      1. **KPI**: 1,000 – 4,000 screeners completed in first 12 months.
   iv. **Action Pillar**: Enrollments in individual self-management program
      1. **KPI**: 100 - 400 enrollments in Season Health in first 12 months.

d. **A note on defining success:**
   i. We are taking an ambitious multi-faceted approach, by designing our program across three Pillars for Meaningful Intervention. Of the three pillars, these are hard to execute even as individual interventions (and oftentimes, these are not even necessarily done well at that level).
   ii. It is important to keep in mind that meaningfully impacting any individual step or pillar can still be considered a success.

iii. As a Healthcare District, program design and execution is within our control, but much is also outside of our control. We should also not lose sight of the necessary time horizon for meaningful change. If there are measurable wins even within a 5 year horizon, this should be celebrated for the impact delivered.

**(4) Cost and Investment Narrative**

a. This is an innovation-driven investment, not a mature grant program. The current $1M budget is equivalent to ~$10 per district resident.
b. The approach has parallels with hospital quality improvement efforts (i.e. it is iterative, multi-year, and data-driven), but with less control because the initiative is externally focused.
c. From the literature plus the experience of others (e.g. Santa Clara County Public Health Department), sustained commitment is required for measurable and meaningful impact.

**Outcomes:** Staff will incorporate board feedback and continue to execute on the strategy and FY 2026 execution priorities.

**List of Attachments:**

**1.** ECHD Population Health Strategy Dialogue: Scope, Approach & Objectives, KPIs presentation

# ECHD Population Health:
## Strategy Dialogue

Dan Woods, Chief Executive Officer
Jon Cowan, Executive Director, Government Relations & Community Partnerships

February 10, 2026

# Agenda

**Population Health Strategy & Prediabetes Initiative Narrative**

- Flows from ECHD Board Approved Strategic Framework
- A new, District-wide initiative aims to educate and create broadly accessible tools to help address prediabetes
- This work is difficult but needed given the magnitude of prediabetes prevalence

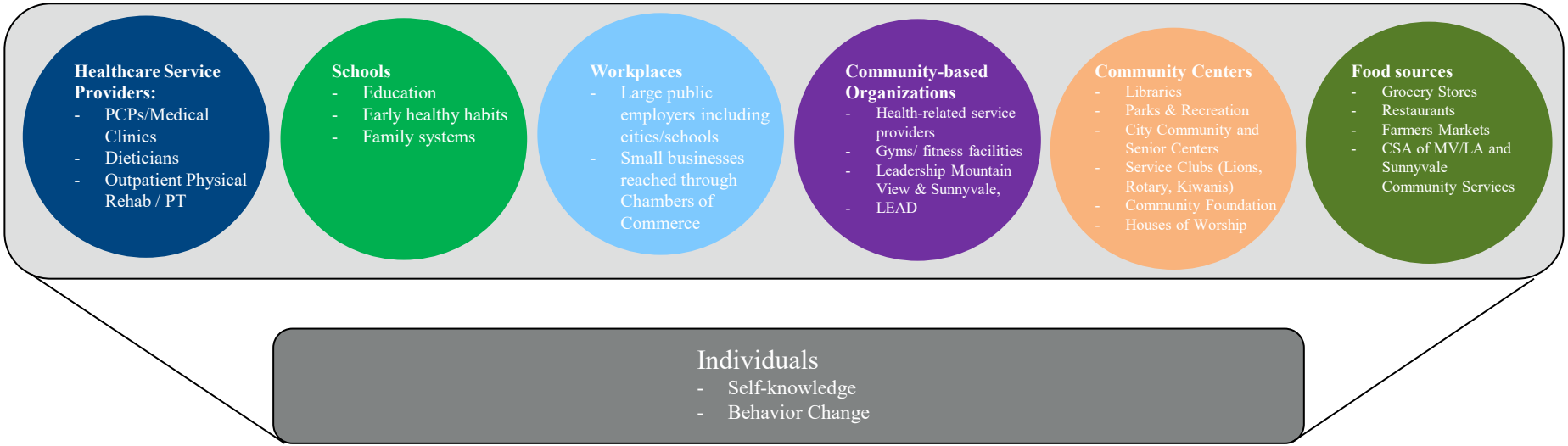
**Today's Purpose**

- Provide additional context for discussion on the Foundational and Workstream 1 elements of the Prediabetes programming approach, including additional detail on goals and KPIs
- Receive additional governance and policy-level feedback

# Prediabetes context

- **Prediabetes is the highest prevalence chronic condition in ECHD**
  - **45%** of ECHD residents have prediabetes, and as many as 8 in 10 are unaware of it
- Prediabetes is **reversible and responsive to behavior change**
- This is a District-wide challenge that requires a broad, multi-year approach involving multiple partners
- At the request of the Board, this comprehensive initiative is an innovative combination of:
  - Self-awareness of prediabetes risk (Foundational)
  - An initial solution (Workstream 1)
  - Additional social support-based solutions in the district geography (Workstream 2 and 3)

# ECHD as a hyperlocal geography where a broad-based approach can help address individual and social factors in prediabetes risk



# Pillars for Meaningful Intervention

## Three Interlocking Pillars

- **What:** Support individuals in the District along the spectrum of Awareness ← → Action ←→ Sustained Behavior Change, which are the key components for successful health intervention strategies according to the research.
- **Approach:** Raise community-wide awareness of prediabetes and personal risk level awareness, offer point solutions for behavior change initiation, and serve as a partner in supporting sustained behavior change, all within the context of a hyperlocal geography

### Awareness

- **What:** Public-health style campaign highlighting risk and encouraging action (e.g. here is your likely risk level. get HbA1C tested, enroll in program if eligible)
- **Approach:** Paid media campaign combined with hyperlocal outreach (e.g. Farmers Markets), directing to ECH/ECHD online risk factor screener. Goal is to reduce # of people who are unaware of their prediabetes (currently ~80,000)
- **KPI:** 1,000-4,000 digital/online risk factor screening completions in first 12 months (CY 2026), as an objective measure of individuals knowing their risk status

### Action

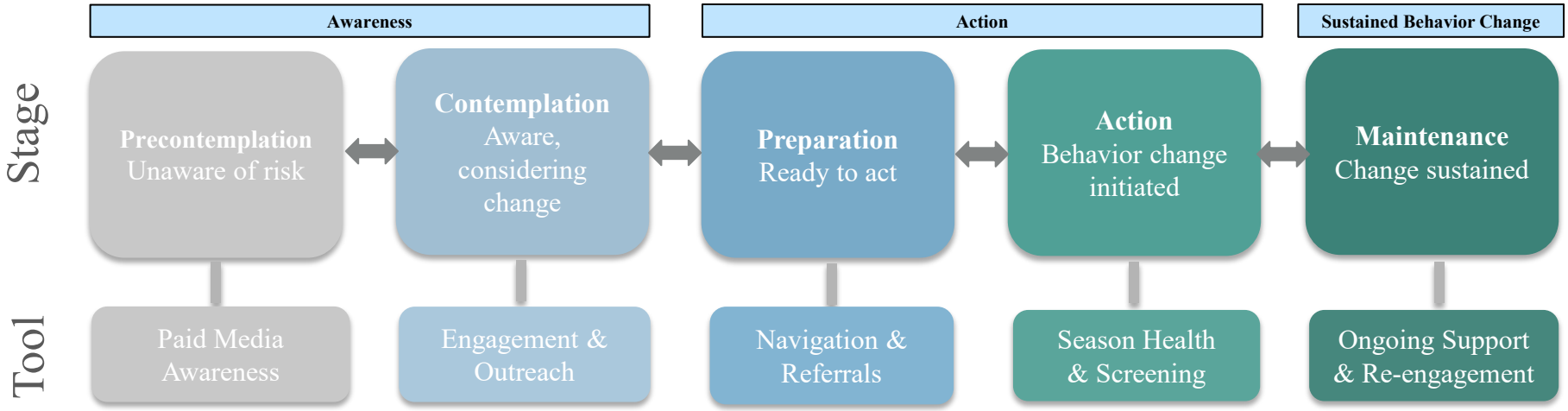
- **What:** Tech-forward solution to help people self-manage their own health and prediabetes risk. Focuses on Food is Health and emphasis on single behavior change initiation.
- **Approach:** Season Health, a virtual dietitian / MNT vendor offering appointments, goal setting, behavior & food tracking, biometric tracking. ECHD subsidization reduces barriers to initial behavior change.
- **KPI:** 100-400 enrollments in first 12 months (CY 2026)

### Sustained Behavior Change

- **What:** "Helping-hands" model of repeat contact with individuals who have engaged with our programs to offer additional opportunities to learn about lifestyle support for health.
- **Approach:** Serve as a convener of services in the District and act as a health communication partner with information on additional resources and offerings that may be relevant to the participant
- **KPI:** Non-clinical measure of repeat engagement (in development)

# Research and Evidence-based Approach

## Stages of Change Model (i.e. Transtheoretical Model of Change)




Behavior change is rarely linear. ECHD is working to create multiple tools to be leveraged by the individual based on their stage of change.

# Research and Evidence-based Approach

## Awareness

- Studies show that individuals **may not fully understand prediabetes or feel it's urgent or important enough to trigger immediate changes** [1]. Communicating the gravity and implications of risk is key.
- A meta-synthesis across twenty studies noted multiple factors in motivation. Chief among them was understanding both the importance and relevance of the condition [2].
- **Individuals must understand that prediabetes is reversible through lifestyle changes** and **understand the value a prevention program could provide to them** [3].

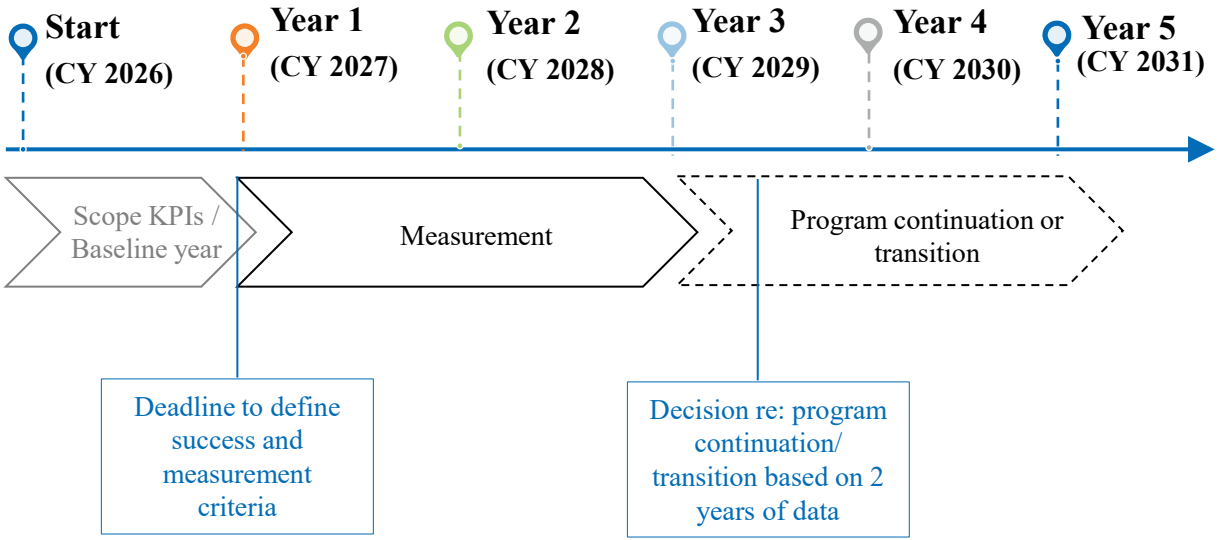
## Action

- Focusing on a **single behavior change** (vs. Multiple behavior changes) can be more feasible to promote, **increase uptake & adherence, reduce cognitive load, and increase self-efficacy**, leading to a greater chance of success than other more intensive programs [4, 5, 6]
- Food-as-medicine / **Food-is-Health as an approach is seeing increased investment** and national focus.
- **Programs must have minimal barriers (e.g. cost, referral mechanism, accessibility, convenience, cultural competency)** [7], and must meet people where they are at (e.g. the Stages of Change theory) [8].

## Sustained Behavior Change

- Behavior change is sustained when people have **ongoing social reinforcement, accountability, and a sense that someone else is invested in their success** (e.g. Social Cognitive Theory) [9, 10].
- Information and access start change. **Habits and relationships sustain it** [11].

# Workstream 1 Measurement and Evaluation




**Scope KPIs / Baseline year:** At the end of Year 1, evaluate/clarify KPIs, how define success, and measurement criteria
**Measurement**: Results at end of Year 3 for a 2-year retrospective period. Includes 90-day learning cycles (review every 30 days, adjust at day ~80-85). Data reviewed monthly for the first six months, then quarterly thereafter

# KPIs and Measurement:

## Why defining goals takes more time at the District level

**Awareness & Screening Campaigns**

Typical focus:
- Reach & impressions
- Screener completions

Key limitation:
- Screeners don't typically offer solutions

**Single Interventions (Provider or Insurer-Paired)**

Typical focus:
- Referrals & visit completion
- Short-term clinical measures

Key limitation:
- Narrow scope and population

**Direct-to-Consumer Interventions**

Typical focus:
- Enrollment & engagement
- Retention over time

Key limitation:
- Limited population-level insight

ECHD is intentionally integrating program types that are typically designed and measured separately This integration expands reach and impact, but also requires a baseline year to define fit-for-purpose metrics and measure change credibly over time.

# KPIs and Measurement:
## Defining Success & Measurement Criteria in Year 1

| Intent | What we are doing in Year 1 |
|---|---|
| Define what success means | • Clearly specify the **changes we are driving** in Year 1: increased awareness of prediabetes risk, increased engagement with screening and prevention resources, and initiation of early behavior change<br>• Align expectations to outcomes that are **appropriate for a first year**, prior to sustained behavior change |
| Ensure metrics are fit for ECHD's role | • Balance typical program metrics with the reality that many targeted individuals may be in earlier Stages of Change<br>• Assess **where those metrics translate directly** and where they require adaptation given ECHD's **district-wide scope**, multiple partners, and population-level focus |
| Establish credible baselines | • Begin data collection to establish **pre-intervention baselines** for awareness, engagement, and participation<br>• Use observed **baseline data to measure change**, rather than relying on assumptions from other programs<br>• Collect information on district members, since we aren't taking a traditional population health management approach with a panel of patients |
| Build scalable measurement infrastructure | • Confirm **who collects what data, when, and how often** across vendors and partners<br>• Validate partner capacity for **consistent, reliable reporting** and ensure privacy, compliance, and system integration |

**Why Year 1 looks different:**
Population-level behavior change requires establishing baselines and validating fit-for-purpose metrics before impact can be credibly assessed.

# KPIs and Measurement:
## Context for Awareness and Action KPIs

| Pillar | KPI | Research | Variability and context to support intentionally wide ranges | District aspects impacting variability of estimates |
|---|---|---|---|---|
| Awareness | 1,000-4,000 screeners completed in first 12 months (CY 2026) | • Across a review of 15 public health campaigns and peer-reviewed studies, about eight demonstrated that 1,000–4,000 people completing an online risk screener in one year is a reasonable range for a campaign of similar scale | • Studies and campaigns represented a very wide range of budgets, coverage areas, paid media channels, and approaches<br>• This is an under-investigated and underfunded area of research. | • **Fast pace of life and intense competition for attention** in the Bay Area environment<br>• Highly multicultural population with **varying perceptions of prediabetes** |
| Action (Workstream 1) | 100-400 enrollments in Season Health in first 12 months (CY 2026) | • A 1-10% conversion / enrollment rate from the risk screener is an ambitious but reasonable goal based on the literature and similar programs | • Program enrollments vary widely based on the population targeted, incentives, anticipated outcomes, and other factors. | • **Effectiveness depends on readiness for change**, consistent with the Stages of Change model<br>• **Long work hours** can limit perceived access to and importance of prevention and lifestyle programs |

The limitations in existing data further underscore the need for a baseline year to evaluate feasibility of our targets for our unique hyperlocal area.

# Notes on defining success

- We are taking an ambitious multi-faceted approach, by designing our program across three Pillars for Meaningful Intervention.
- Of the three pillars (Awareness, Action, and Sustained Behavior Change), these are all hard even as individual interventions (and often not even done well at that level).
- It is important to keep in mind that meaningfully impacting any individual step can still be considered success.
- As a Healthcare District, we can control a lot about program design and execution, but much is also outside of our control (e.g., no patient relationship; no financial relationship).
- We should also not lose sight of the necessary time horizon for meaningful change. If there are measurable wins even within 5 years, this should be celebrated for the impact delivered.

# Cost and Investment framing

- This is an innovation-driven investment, not a mature grant program.
- $1M budget is equivalent to ~$10 per district resident (since ~100,000, or 45%, of District residents have prediabetes)
- The approach is comparable to hospital quality improvement efforts (but with less control because externally-focused)
  - Iterative
  - Multi-year
  - Data-driven
- Sustained commitment is required for measurable and meaningful impact

# Dialogue

# Dialogue prompt:

1. What clarifying questions do you have about the current strategy?

# Appendix


https://www.elcaminohealthcaredistrict.org/prediabetes


https://www.elcaminohealthcaredistrict.org/prediabetes

# Population Health – 3-5 Year Strategy for Prediabetes

**Foundational: Awareness & Execution Enablement**

- **What:** Drive awareness of Population Health initiative and individual Prediabetes risk; plus resourcing & staffing alignment
- **Approach:** Develop campaign with strong call-to-action for personal risk awareness; addressing resourcing needs

| Workstream 1: Individual-self management for adults | Workstream 2: Group/social programming for adults | Workstream 3: Programming for youth |
|---|---|---|
| • **What:** Tech-forward solution to help people self-manage their own health and prediabetes risk<br>• **Key considerations**: Focus on Food is Health, single behavior change<br>• **Approach:** Virtual dietician / MNT vendor offering appointments, goal setting, behavior & food tracking, biometric tracking | • **What:** Group-based approach to enhance peer support effects<br>• **Key considerations**: Maximize impact through collaborating with existing grantees and new partners to activate the network<br>• **Approach:** Investigate the most promising interventions for building social support and addressing time demands, e.g. education, peer / social support, and challenges/rewards | • **What:** Education-centric approach to encourage healthy habits in children and adolescents<br>• **Key considerations**: Goal is to address healthy habits early, before chronic conditions start to develop<br>• **Approach:** Partner with existing grantees or new partners. Consult the schools, camps, etc. on their desire for programming, what gaps exist |

* 3-5 Year Strategy and Profile approved at June 2025 ECHD Board Meeting

# Workstream 1: Individual self-management for adults [Program description]

- After a thorough vendor market assessment, as well as research/literature-based analysis of options, we identified the Food-is-Health (or Food-as-Medicine) category of vendor as the most well-aligned with the goals of our program and the ECHD population.
- A formal RFP process with a final decision completed by end of FY 2025; Implementation in FY 2026

| Key Program element | Description | Empirical evidence examples / supporting literature | Fit for ECHD and additional considerations |
|---|---|---|---|
| **"Food-is-Health" digital health offering** | • Digitally-delivered nutrition and diet support from a Registered Dietitian<br>• Program will be delivered primarily through digital interface, including virtual dietitian / nutrition coaching, goal setting, food tracking, biometric data integration, and more. | - Focusing on a single behavior change (vs. Multiple behavior changes) can increase uptake & adherence, reduce cognitive load, and increase self-efficacy, leading to a greater chance of success than other more intensive programs (1)<br>- Single lifestyle change may be more feasible to promote (1,2,3)<br>- Food-as-medicine / Food-is-Health as an approach is seeing increased investment and national focus | • Greater chance of reaching a broader audience & driving<br>• Food is approachable and relatable ("everybody eats")<br>• Food-is-Health vendors have broader insurance coverage = better for ECHD cost management |

# Workstream 1: Individual self-management for adults [Measurement]

Measures of success will likely include a subset of the following:

- Enrollment, engagement, and retention metrics
- Knowledge of prediabetes risk factors and other education metrics, and of prevention-based healthy lifestyle practices
- Prior knowledge of their prediabetes status
- Adherence rates to diet & nutrition plans (e.g. servings of fruits and vegetables, water intake)
- Adherence to and consistency in recording meals, activity, and other metrics that are known to enhance program success
- Change in self-reported health measures
- Cross-participation between programs in Workstream 1 (individual self-management) and Workstream 2 (group/social programming).
- Physician follow-up (e.g. likelihood of follow up with physician as result of program)

# Key Learnings from Research

| Topic | Learnings | Details | Implications |
|---|---|---|---|
| Single behavior change v.s. Multiple Behavior changes | • Multiple behavior interventions are more effective for reducing prediabetes risks and Type 2 diabetes risks, but only if engagement and adherence to interventions remains high (1, 2).<br>• Single behavior change interventions may have more uptake and adherence, and more success of dietary or physical activity change (independently), due to the lower cognitive load and higher self-efficacy (3,4,5). | • Focusing on one behavioral change at a time may be more achievable for most people - interventions targeting a single behavior reduce cognitive burden and facilitate long-term maintenance of change (3).<br>• A synthesis of meta-analysis found that single behavior interventions resulted in larger and more reliable effect sizes for changing behaviors than combined approaches (4).<br>• Another study compared automated interventions for four groups: diet only, physical activity only, diet + physical activity, and a control group (5). They found that the diet only intervention was effective and produced a greater intake of fruits and vegetables compared to the combined diet + physical activity intervention. | ✅ Utilize a single behavior change intervention to increase uptake and adherence, reduce cognitive load, increase self-efficacy and lead to a greater chance of success for individual behavior change. |

# Key Learnings from Research

| Topic | Learnings | Details | Implications |
|---|---|---|---|
| Enrollment and engagement | • Significant outreach efforts with multiple contact attempts are often required to engage individuals in behavioral and lifestyle change programs, regardless of modality (in person or mHealth) (9,10).<br>• Invitations and endorsement from trusted providers, professionals, community members, family members, and friends can encourage engagement (11,12). | • Even after receiving multiple reminders, some individuals reported waiting months or years before enrolling in a lifestyle-change program, citing time constraints or not feeling "ready." (9, 10). In the NHS digital DPP in the UK, providers sent monthly email and letter reminders to people who initially declined or didn't respond (11). This persistent outreach was necessary to capture additional participants.<br>• Endorsement by trusted professionals can yield greater enrollment rates. For example, the NHS digital DPP in the UK contacted 2,051 eligible individuals, yielding only about a 3% initial expression of interest (11). When personal invitations came via patients' own primary care practice (a presumably more trusted source), response rates were higher (~11%) (11). This suggests that trusted, personalized channels (like one's doctor's office) may increase the likelihood of signup. | ✅ Leverage repeated and multi-channel contacts (emails, letters, calls, in-person prompts), which are often needed to recruit participants.<br>✅ Use trusted messengers (like personal physicians or community leaders) to greatly enhance the likelihood that individuals will enroll in digital behavior change programs.<br>✅ Focus on one single, compelling lifestyle change (e.g., targeted healthy-eating initiative), as it may be more feasible to promote, especially if a program has limited resources for repeated messaging and follow-up. |

# Key Learnings from Research

| Topic | Learnings | Details | Implications |
|---|---|---|---|
| Motivation after prediabetes diagnosis | • Over 8 in 10 people with prediabetes aren't aware they have the condition (13).<br>• People often become more motivated after discovering they have prediabetes (14), but enrollment may still be modest unless a program is easy to access and emphasizes the seriousness and manageability of prediabetes (15,16,17). | • The label of "prediabetes" can have varying psychological effects. For some, it increases motivation – it's a wake-up call that spurs them to improve their diet or activity (14). For others, it may induce anxiety or fatalism (worrying about developing diabetes, or conversely, feeling the outcome is inevitable) (14). Thus, the way the diagnosis is communicated is important: patients benefit from hearing that *prediabetes is a reversible condition*, not a guaranteed path to diabetes.<br>• Studies show that many individuals may not fully understand prediabetes or feel it's urgent or important enough to trigger immediate changes (14). In some instances, people might downplay the risk ("it's not *real* diabetes yet") or feel unsure what to do, leading to inaction. This indicates that additional support and guidance are needed beyond the diagnosis conversation (14).<br>• A meta-synthesis across twenty studies (including 552 individuals) noted multiple factors in motivation. And chief among them was understanding the importance and relevance of the diagnosis (15).<br>• Patients must understand that prediabetes is reversible through lifestyle and behavioral changes and understand the value a prevention program could provide to them (16).<br>• Programs must have minimal barriers (e.g., cost, referral mechanism, accessibility, convenience) (17). | ✅ Focus on those who already know they have prediabetes, as they tend to be more motivated, especially if the intervention removes or mitigates key barriers (cost, time, etc.).<br>✅ If able, reach the undiagnosed or newly diagnosed population, as this could be high-impact (but could require more investment in education and outreach).<br>✅ Outreach should be: tailored and relevant, appeal to individuals to take action, emphasize convenience and ease along with low barriers to engagement. |

# Key Learnings from Research

| Topic | Learnings | Details | Implications |
|---|---|---|---|
| Best practices for program tools and support resources | • The design quality, usability, and available support systems in a digital prediabetes program significantly impact sign-up rates, engagement, and retention (18,19,20). Features like health coaching, self-monitoring tools, and peer support boost adherence, while fully automated interventions often see lower participation rates (19). | • **User-Friendly Design & Perceived Effectiveness Matter**: If an app is hard to use or doesn't demonstrate clear benefits, users are less likely to sign up and stay engaged (18).<br>• **Health Coaching & Self-Monitoring Increase Retention**: Digital diabetes prevention apps that integrate coaching, personalized goal tracking, and progress visualization improve long-term engagement (19).<br>• **Social Support Enhances Accountability**: Programs with peer forums, group chats, or coach interactions result in higher adherence compared to isolated, self-guided interventions (19).<br>• **Human Interaction (Even Remote) Boosts Success**: Regular check-ins via phone, video, or chat create a sense of accountability and motivation, improving program retention (19).<br>• **Incentives and personalized nudges are important**: A scoping review assessing remote digital health studies found that providing incentives or nudges, such as regular reminders and personalized feedback, led to increased study completion rates. Specifically, studies that implemented these strategies observed a median completion rate of 62%, compared to lower rates in studies without such interventions (20). | ✅ Prioritize an intuitive, engaging app design to reduce friction in user experience.<br>✅ Integrate coaching or real-time feedback features to guide participants.<br>✅ Include peer support groups or community features for accountability and motivation.<br>✅ Leverage human touchpoints (text, call, video chat) rather than relying solely on automated approaches.<br>✅ Consider integration with wearables a "nice-to-have", not a requirement. |

# Current Terms for El Camino Hospital Board Directors

**Category 1 –El Camino Healthcare District Board Directors**

(These directors serve four (4)-year terms coinciding with voter election)

| Name | First Full Term | Second Term | Third Term | Fourth Term | Fifth Term | Termed Out |
|---|---|---|---|---|---|---|
| Zoglin | Dec. 2008 | Dec. 2012 | Dec. 2016 | Dec. 2020 | Dec 2024 | None |
| Miller | Dec. 2012 | Dec. 2016 | Dec. 2020 | Dec. 2024 | | None |
| Fung | Dec. 2014 | Dec. 2018 | Dec. 2022 | | | |
| Ting | Dec. 2018 | Dec. 2022 | Dec. 2026 | | | None |
| Somersille | Dec. 2020 | Dec. 2024 | Dec. 2028 | | | None |

**Category 2 – Not Serving on El Camino Healthcare District Board**

(These directors serve up to four (4) three (3)-year terms)

(for illustrative purposes only, chart assumes reappointment until termed out)

| Name | First Full Term | Second Term | Third Term | Fourth Term | Termed Out |
|---|---|---|---|---|---|
| Chen | July 2015 | July 2018 | July 2021 | July 2024 | June 2027 |
| Rebitzer | July 2017 | July 2020 | July 2023 | July 2026 | June 2029 |
| Po | July 2019 | July 2022 | July 2025 | July 2028 | June 2031 |
| Watters | July 2021 | July 2024 | July 2027 | July 2030 | June 2033 |
| Doiguchi | July 2023 | July 2026 | July 2029 | July 2032 | July 2035 |

Updated Jan. 2026

# FY26 Competency Matrix
# Rating Tool & Rating Scale

| **Level of Knowledge/Experience (Self-Rate)**<br>1 = None (no background/experience)<br>2 = Minimal<br>3 = Moderate/Broad<br>4 = Competent<br>5 = Expert | | Director 1 | Director 2 | Director 3 | Director 4 | Director 5 | Director 6 | Director 7 | Director 8 | Director 9 | Director 10 | AVERAGE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **COLLECTIVE COMPETENCIES:** Knowledge and skills that the board as a whole needs, and therefore, should be strong attributes of one or more but not necessarily all members. | | | | | | | | | | | | |
| **FUNCTIONAL EXPERTISE** | 1. Board or Corporate Governance Experience (outside ECH) | 4 | 5 | 2 | 5 | 4 | 3 | 3 | 3 | 5 | 2 | 3.6 |
| | 2. Commercial Real Estate / Healthcare Real Estate | 2 | 4 | 3 | 2 | 2 | 2 | 1 | 4 | 3 | 2 | 2.5 |
| | 3. Community Relations / Government (federal, state, or local) | 4 | 4 | 3 | 5 | 4 | 4 | 4 | 3 | 2 | 4 | 3.7 |
| | 4. Finance / Investment | 3 | 5 | 4 | 1 | 4 | 3 | 2 | 4 | 5 | 5 | 3.6 |
| | 5. Healthcare Mergers & Acquisitions / Physician Strategy | 3 | 3 | 3 | 1 | 4 | 4 | 4 | 4 | 2 | 3 | 3.1 |
| | 6. Healthcare Policy | 5 | 3 | 4 | 2 | 5 | 4 | 4 | 4 | 2 | 2 | 3.5 |
| | 7. Large Company Executive Management (Public or Private CEO, CFO, CIO, COO, President, or Other Senior Executive Position) | 1 | 5 | 3 | 1 | 4 | 5 | 1 | 3 | 4 | 4 | 3.1 |
| | 8. Marketing / Branding / Communications | 4 | 4 | 3 | 4 | 3 | 3 | 2 | 3 | 4 | 5 | 3.5 |
| | 9. Healthcare Quality and Patient Safety | 3 | 3 | 5 | 2 | 4 | 4 | 5 | 5 | 2 | 2 | 3.5 |
| | 10. Regulatory, Legal & Compliance | 3 | 5 | 3 | 1 | 3 | 3 | 2 | 3 | 2 | 2 | 2.7 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 11. Strategy | 3 | 5 | 4 | 3 | 4 | 5 | 3 | 4 | 5 | 4 | 4 |
| | 12. Technology Leadership | 2 | 3 | 4 | 3 | 5 | 3 | 1 | 3 | 3 | 4 | 3.1 |
| **UNIVERSAL ATTRIBUTES:** Personal qualifications required of all board members. | | | | | | | | | | | | |
| 1. | **Analytical Thinker**: separates the important from trivial | 5 | 5 | 4 | 3 | 5 | 5 | 4 | 5 | 5 | 4 | 4.5 |
| 2. | **Collaborative**: feels collaboration is essential for success | 4 | 4 | 5 | 5 | 4 | 5 | 5 | 5 | 5 | 3 | 4.5 |
| 3. | **Community-Oriented**: demonstrate commitment to the ECH mission, vision, and values and to the communities served | 4 | 4 | 4 | 5 | 3 | 4 | 5 | 5 | 5 | 5 | 4.4 |
| **DEMOGRAPHICS** | | | | | | | | | | | | |
| 1. | **Self-Assessed Average Score** | 3.33 | 4.13 | 3.60 | 2.87 | 3.87 | 3.80 | 3.07 | 3.87 | 3.60 | 3.40 | **3.55** |

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING COVER MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Raju Iyer, Chief Financial Officer
**Date:** February 10, 2026
**Subject:** YTD FY2026 Financial Update (as of 12/31/2025)

**Purpose:** To provide the Finance Committee with an overview of financial results for Period 6 and YTD FY2026, including comparisons to Budget and Prior Year (PY), and to seek approval of the financials. This memo highlights key financial trends and governance-level considerations; detailed operational and variance analyses are provided in the attached materials.

## Executive Summary – Period 6 (December 2025)

### Overall Performance

Period 6 results reflect continued strength in outpatient and procedural activity, which more than offset modest inpatient volume softness. Revenue and operating margin performance exceeded budget expectations, supported by disciplined expense management and sustained labor productivity improvements. Net income significantly exceeded budget, driven mostly by favorable non-operating investment performance.

### Key Volume Observations

- Inpatient average daily census (ADC) remained below Budget and Prior Year, consistent with ongoing utilization trends.
- Outpatient volumes, including emergency department visits and procedural cases, exceeded both Budget and Prior Year and were the primary contributors to favorable revenue performance.
- Detailed volume trends by service line are included in the **Detailed Volume and KPI Dashboard.**

### Financial Performance

- **Total Operating Revenue:** $161.2M, favorable to Budget by $9.2M (6.1%) and higher than PY by $12.6M (8.4%).
- **Operating Margin:** $23.1M, favorable to Budget by $8.6M (59.3%) and slightly below PY by $0.7M (2.9%).
- **Operating EBIDA:** $31.2M, favorable to Budget by $8.2M (35.8%) and slightly below PY by $0.8M (2.5%).
- **Net Income:** $56.2M, favorable to Budget by $36.2M (180.6%) and higher than PY by $37.9M (207.4%).

### YTD FY2026 Performance (as of December 31, 2025)

### Year-to-Date Overview

Through December 31, 2025, financial performance remains ahead of Budget across all major operating metrics. Revenue growth continues to be driven by outpatient activity, while expense performance reflects effective management of labor productivity and premium pay. A portion of year-to-date net income favorability is attributable to market-driven investment gains rather than recurring operating performance.

### Key Results

- **Total Operating Revenue:** $917.9M, favorable to Budget by $16.6M (1.8%) and higher than PY by $71.0M (8.4%).
- **Operating Margin:** $100.3M, favorable to Budget by $25.8M (34.5%) and higher than PY by $15.2M (17.9%).

- **Operating EBIDA:** $151.6M, favorable to Budget by $23.8M (18.6%) and higher than PY by $16.3M (12.0%).
- **Net Income:** $227.9M, favorable to Budget by $122.4M (116.0%) and higher than PY by $70.6M (44.8%).

**Key Volumes:**

- **ADC:** CY 300.5 (1.8% unfavorable to Budget), PY 307.6 (2.3% lower)
- **Adjusted Discharges:** CY 23,316 (3.4% favorable to Budget), PY 22,239 (4.8% higher)
- **ED Visits:** CY 42,180 (6.0% favorable to Budget), PY 40,058 (5.29% higher)
- **OP Visits / Procedural Cases:** CY 84,704 (8.4% favorable to Budget), PY 75,523 (12.2% higher)

**Executive Summary – Stand-Alone (District) Financials (as of 12/31/2025):**

| | |
|---|---|
| **Total Operating Revenue ($):** | $11.1M, unfavorable to budget by $4.5 million or 29%. Unfavorable variance is due to the timing of property tax receipts. |
| **Net Income ($):** | -$0.2M, unfavorable to budget by $6.5M or 103%. Unfavorable variance is due to the timing of property tax receipts and disbursement of grant funds, which was budgeted for January 2026. |

**Recommendation:**

- Recommend the District Board of Directors approve the Consolidated and Stand-Alone (District) YTD FY2026 financials.

**List of Attachments:**

- Consolidated and Stand-Alone (District) Financials – YTD FY2026 (as of 12/31/2025)

# District Board Finance Presentation Fiscal Year 2026

## 7/1/2025-12/31/2025

Raju Iyer, CFO

February 10, 2026

# Table of Contents

## ECHD Consolidated Financial Statements (Includes El Camino Hospital)



## ECHD Stand-Alone Financial Statements



NOTE: Accounting standards require that audited financial statements for El Camino Healthcare District be presented in consolidated format, including El Camino Hospital and its controlled affiliates. In an effort to help ensure public accountability and further ensure the transparency of the District's operations, the District also prepares internal, "Stand-Alone" financial statements which present information for the District by itself.

# Consolidated Comparative Balance Sheet ($ Millions)

## (Includes El Camino Hospital)

| | Dec 31, 2025 | June 30, 2025 Audited w/o Eliminations |
|---|---|---|
| **ASSETS** | | |
| **Current Assets** | | |
| Cash & Investments | $645 | $539 |
| Patient Accounts Receivable, net | 241 | 241 |
| Other Accounts and Notes Receivable | 60 | 47 |
| Inventories and Prepaids | 56 | 54 |
| **Total Current Assets** | **1,002** | **881** |
| **Board Designated Assets** | | |
| Foundation Reserves | 17 | 18 |
| Community Benefit Fund | 32 | 30 |
| Operational Reserve Fund [1] | 212 | 212 |
| Workers Comp, Health & PTO Reserves | 78 | 78 |
| Facilities Replacement Fund [2] | 638 | 620 |
| Catastrophic & Malpractice Reserve [3] | 35 | 43 |
| **Total Board Designated Assets** | **1,011** | **1,001** |
| **Non-Designated Assets** | | |
| Funds Held By Trustee [4] | 29 | 35 |
| Long Term Investments | 804 | 754 |
| Other Investments | 55 | 53 |
| Net Property Plant & Equipment | 1,396 | 1,347 |
| Deferred Outflows of Resources | 40 | 41 |
| Other Assets | 280 | 268 |
| **Total Non-Designated Assets** | **2,604** | **2,497** |
| **TOTAL ASSETS** | **$4,618** | **$4,379** |

| | Dec 31, 2025 | June 30, 2025 Audited w/o Eliminations |
|---|---|---|
| **LIABILITIES & FUND BALANCE** | | |
| **Current Liabilities** | | |
| Accounts Payable & Accrued Exp [5] | $228 | $218 |
| Bonds Payable - Current | 19 | 19 |
| Bond Interest Payable | 12 | 11 |
| Other Liabilities | 22 | 20 |
| **Total Current Liabilities** | **281** | **268** |
| **Deferred Revenue** | **1** | **2** |
| **Deferred Revenue Inflow of Resources** | **81** | **88** |
| **Long Term Liabilities** | | |
| Bond Payable | 617 | 622 |
| Benefit Obligations | 32 | 34 |
| Other Long-term Obligations | 26 | 26 |
| **Total Long Term Liabilities** | **675** | **683** |
| **Fund Balance** | | |
| Unrestricted | 3,318 | 3,092 |
| Minority Interest | - | - |
| Board Designated & Restricted | 261 | 246 |
| Capital & Retained Earnings | 0 | 0 |
| **Total Fund Balance** | **3,579** | **3,338** |
| **TOTAL LIAB. & FUND BAL.** | **$4,618** | **$4,379** |

*Note: Totals may not agree due to rounding. See page 5 for footnotes.*

# Consolidated Comparative Statement of Revenues & Expenses ($ Millions)
## Year-to-Date through December 31, 2025
### (Includes El Camino Hospital)

| | Actual | Budget | Fav (Unfav) Variance | Prior YTD FY Actual |
|---|---|---|---|---|
| Net Patient Revenue [6] | 888 | 863 | 25 | 813 |
| Other Operating Revenues [7] | 41 | 34 | 7 | 34 |
| **Total Operating Revenues** | **929** | **897** | **32** | **847** |
| Wages and Benefits | 469 | 465 | (4) | 436 |
| Supplies | 121 | 127 | 6 | 114 |
| Purchased Services | 153 | 149 | (4) | 131 |
| Other | 32 | 30 | (2) | 30 |
| Depreciation | 41 | 43 | 2 | 41 |
| Interest | 10 | 10 | (1) | 9 |
| Total Operating Expense [8] | **826** | **824** | **(3)** | **762** |
| **Operating Income** | **103** | **73** | **30** | **85** |
| Non-Operating Income [9] | 138 | 38 | 100 | 81 |
| **Net Income** | **241** | **111** | **130** | **166** |

*Note: Totals or variances may not agree due to rounding. See page 5 for footnotes.*

# El Camino Healthcare District

## Notes to Consolidated Financial Statements

### Current FY2026 Actual to Budget

### (Includes El Camino Hospital)

1) A 60-day reserve of expenses based on this fiscal year's Hospital budget.
2) The current period Facilities Replacement Fund is comprised of ($ Millions):

| | |
|---|---|
| ECH Capital Replacement Fund (i.e. Funded Depr.) | $519 |
| ECH Women's Hospital Expansion | 61 |
| ECHD Appropriation Fund (aka: Capital Outlay) | 30 |
| ECH Campus Completion Project | 28 |
| | **$638** |

3) The current period Catastrophic & Malpractice Fund is comprised of ($ Millions):

| | |
|---|---|
| ECH Catastrophic Fund (aka: Earthquake Fund) | $33 |
| ECH Malpractice Reserve | 2 |
| | **$35** |

4) Funds Held by Trustee now only reflect the GO funds of the District.
5) The difference is not significant.
6) The difference is not significant.
7) The difference is not significant.
8) The difference is not significant.
9) The significant increase in non-operating income was due to strong investment returns.

# El Camino Healthcare District

## Stand-Alone Comparative Balance Sheet ($ Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

| | Dec 31, 2025 | Audited June 30, 2025 | | Dec 31, 2025 | Audited June 30, 2025 |
|---|---|---|---|---|---|
| **ASSETS** | | | **LIABILITIES & FUND BALANCE** | | |
| Cash & cash equiv [1] | $13,472 | $27,374 | Accounts payable | $2,861 | $8 |
| Short term investments [1] | 6,946 | 5,638 | Current portion of bonds | 3,552 | 3,411 |
| Due fm Retiree Health Plan [2] | 0 | 0 | Bond interest payable [10] | 3,212 | 5,116 |
| S.C. M&O Taxes Receivable [3] | 512 | 0 | Other Liabilities | 395 | 403 |
| Other current assets [3a] | 60 | 68 | | | |
| **Total current assets** | $20,990 | $33,080 | **Total current liabilities** | $10,019 | $8,938 |
| Operational Reserve Fund [4] | 1,500 | 1,500 | | | |
| Capital Appropriation Fund [5] | 29,924 | 27,323 | | | |
| Capital Replacement Fund [6] | 5,607 | 5,607 | Deferred income | 0 | 68 |
| Community Partnership Fund [7] | 15,654 | 12,089 | Bonds payable - long term | 91,952 | 95,517 |
| **Total Board designated funds** | $52,685 | $46,518 | **Total liabilities** | **$101,971** | **$104,523** |
| **Funds held by trustee [8]** | **$28,801** | **$35,333** | **Fund balance** | | |
| **Capital assets, net [9]** | **$10,636** | **$10,638** | Unrestricted fund balance | $83,108 | $74,004 |
| | | | Restricted fund balance | (71,967) | (52,957) |
| | | | **Total fund balance [11]** | **$11,141** | **$21,047** |
| **TOTAL ASSETS** | **$113,112** | **$125,570** | **TOTAL LIAB & FUND BALANCE** | **$113,112** | **$125,570** |

*Note: Totals may not agree due to rounding. See page 9 for footnotes.*

# YTD Stand-Alone Stmt of Revenue and Expenses ($ Thousands)
# Comparative Year-to-Date December 31, 2025

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

| | | Actual | Current Year Budget | Variance | Prior Full Year Actual |
|---|---|---|---|---|---|
| | **REVENUES** | | | | |
| (A) | Ground Lease Revenue [12] | $ 68 | 59 | $ 9 | $ 105 |
| (B) | Redevelopment Taxes [13] | - | 125 | (125) | - |
| (B) | Unrestricted M&O Property Taxes [13] | 8,148 | 7,634 | 514 | 11,450 |
| (B) | Restricted M&O Property Taxes [13] | 3,712 | 7,875 | (4,163) | 15,646 |
| (B) | G.O. Taxes Levied for Debt Service [13] | 1,872 | 1,350 | 522 | 3,746 |
| (B) | IGT/PRIME Medi-Cal Program [14] | (3,331) | (2,443) | (888) | (5,193) |
| (B) | Investment Income (net) | 583 | 1,000 | (417) | 3,187 |
| (B) | Other income | - | - | - | - |
| | **TOTAL NET REVENUE** | 11,052 | 15,600 | (4,548) | 28,941 |
| | **EXPENSES** | | | | |
| (A) | Wages & Benefits [15] | 19 | 31 | 12 | 29 |
| (A) | Professional Fees & Purchased Svcs [16] | 378 | 411 | 33 | 986 |
| (A) | Supplies & Other Expenses [17] | 143 | 27 | (116) | 29 |
| (B) | G.O. Bond Interest Expense (net) [18] | 3,100 | 3,308 | 208 | 5,243 |
| (B) | Community Partnership Expenditures [19] | 7,598 | 5,500 | (2,098) | 7,358 |
| (A) | Depreciation / Amortization | 3 | 3 | - | 5 |
| | **TOTAL EXPENSES** | 11,241 | 9,280 | (1,961) | 13,650 |
| | **NET INCOME** | $ (191) | $ 6,320 | $ (6,511) | $ 15,290 |

(A) Operating Revenues & Expenses
(B) Non-operating Revenues & Expenses

| | **RECAP STATEMENT OF REVENUES & EXPENSE** | |
|---|---|---|
| (A) | Net Operating Revenues & Expenses | $ (475) |
| (B) | Net Non-Operating Revenues & Expenses | 284 |
| | **NET INCOME** | $ (191) |

*Note: Totals may not agree due to rounding. See page 10 for footnotes.*

# El Camino Healthcare District

## Comparative YTD Stand-Alone Stmt of Fund Balance Activity ($ Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

| | Dec 31, 2025 | June 30, 2025 |
|---|---|---|
| **Fiscal year beginning balance** | **$ 21,047** | **$ 12,150** |
| Net income year-to-date | $ (191) | $ 15,291 |
| Transfers (to)/from ECH: | | |
| IGT/PRIME Funding [20] | $ 3,331 | $ 5,134 |
| Capital Appropriation projects [21] | $ (13,045) | (11,528) |
| **Fiscal year ending balance** | **$ 11,141** | **$ 21,047** |

*Note: Totals may not agree due to rounding. See page 10 for footnotes.*

# Notes to Stand-Alone Financial Statements

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

**(1) Cash & Short Term Investments –** The decrease from June 30 is due to the timing of M&O receipts being received in the current year.

**(2) Due from Retiree Health Plan –** The monies due from Trustee for District's Retiree Healthcare Plan.

**(3) S.C. M&O Taxes Receivable –** The increase is due to accruing for M&O taxes to be received in subsequent months.

**(3a) Other Current Assets** – Inter-company liability with affiliates.

**(4) Operational Reserve Fund** – Starting in FY 2014, the Board established an operational reserve for unanticipated operating expenses of the District.

**(5) Capital Appropriation Fund –** The increase is due to the establishment of the year-end FY24 funding set aside for the completion of the MV Campus.

**(6) Capital Replacement Fund** – Formerly known as the Plant Facilities Fund (AKA - Funded Depreciation) which reserves monies for the major renovation or replacement of the portion of the YMCA (Park Pavilion) owned by the District.

**(7) Community Partnership Fund –** This fund retains unrestricted (Gann Limit) funds to support the District's operations and primarily to support its Community Partnership Programs.

**(8) Funds Held by Trustee –** Funds from General Obligation tax monies, being held to make the debt payments when due.

**(9) Capital Net Assets -** The land on which the Mountain View Hospital resides, a portion of the YMCA building, property at the end of South Drive (currently for the Road Runners operations), and a vacant lot located at El Camino Real and Phyllis.

**(10) Bond Interest Payable –** The decrease is a timing issue and will increase in subsequent months to be comparable to the June 30 amount.

**(11) Fund Balance –** The positive fund balance is a result of the General Obligation bonds which assisted in funding the replacement hospital facility in Mountain View. Accounting rules required the District to recognize the obligation in full at the time the bonds were issued ; receipts from taxpayers will be recognized in the year they are levied.

# Notes to Stand-Alone Financial Statements

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

**(12) Other Operating Revenue –** Lease income from El Camino Hospital for its ground lease with the District.

**(13) Taxes: Redevelopment, M&O, G.O.** – Tax receipts during the period. G.O. Taxed Levied for Debt will catch up in January as the semi-annual disbursement will occur from the County.

**(14) IGT/PRIME Expense** – Payments in support of the PRIME or IGT programs.

**(15) Wages & Benefits –** IRS regulations require that board of directors be compensated as employees.

**(16) Professional Fees & Services** – Actual detailed below:

| | |
|---|---|
| • Community Partnership Support from ECH (54% of SW&B) | $ 250 |
| • Communications Support for District | 115 |
| • Committee Meeting | 10 |
| • Other / Bond filing cost | 3 |
| | $ 378 |

**(17) Supplies & Other Expenses –** Actual detailed below:

| | |
|---|---|
| • Marketing | 87 |
| • LAFCO & CSDA | 32 |
| • Bank Fees | 15 |
| • Education | 7 |
| • Other | 2 |
| | $ 143 |

**(18) G.O. Bond Interest Expense –** It is to be noted that on March 22, 2017 the District refunded $99M of its remaining $132M 2006 G.O. bond issue. Refunding of the 2006 G.O. debt, given current interest rates, caused a net present value savings of $7M.

**(19) Community Partnership Expenditures –** Starting in FY2014, the District is directly operating its Community Partnership Program at the District level. This represents amounts expended to grantees and sponsorships thus far in this fiscal year. Note the major payments to recipients are made in August & January of the fiscal year.

**(20) IGT/PRIME Funding** – Transfers from ECH for participation in the PRIME or IGT program thus far in FY 2026.

**(21) Capital Appropriation Projects Transfer** – Net increase of last year transferred out and establishing current year.

# Sources & Uses of Tax Receipts ($Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

| **Sources of District Taxes** | **12/31/25** |
|---|---|
| (1) Maintenance and Operation and Government Obligation Taxes | $13,732 |
| (2) Redevelopment Agency Taxes | - |
| **Total District Tax Receipts** | **$13,732** |
| **Uses Required Obligations / Operations** | |
| (3) Government Obligation Bond | 5,314 |
| **Total Cash Available for Operations, CB Programs, & Capital Appropriations** | **8,418** |
| (4) Capital Appropriation Fund – Excess Gann Initiative Restricted* | 3,712 |
| **Subtotal** | **4,706** |
| (5) Operating Expenses (Net) | 475 |
| **Subtotal** | **4,231** |
| (6) Capital Replacement Fund (Park Pavilion) | 4 |
| **Funds Available for Community Partnership Programs** | **$4,227** |
| *Gann Limit Calculation for FY2026 | $12,221 |

| | |
|---|---|
| (1) M&O and G.O. Taxes | • Cash receipts from the 1% ad valorem property taxes and Measure D taxes |
| (2) Redevelopment Agency Taxes | • Cash receipts from dissolution of redevelopment agencies |
| (3) Government Obligation Bond | • Levied for debt service |
| (4) Capital Appropriation Fund | • Excess amounts over the Gann Limit are restricted for use as capital |
| (5) Operating Expenses | • Expenses incurred in carrying out the District's day-to-day activities |
| (6) Capital Replacement Fund | • Fund to ensure that the District has adequate resources to fund repair and replacement of its capital assets (Park Pavilion) |

# Q & A

# El Camino Healthcare District Board of Directors
# Open Session Meeting Minutes
# Tuesday, November 18, 2025

**El Camino Hospital | Sobrato Boardroom 1 | 2500 Grant Road, Mountain View, CA**

**Board Members Present**
**John Zoglin**, Chair
**Carol A. Somersille, MD,** Vice Chair
**Julia E. Miller,** Secretary/Treasurer
**Peter C. Fung, MD**
**George O. Ting, MD**

**Board Members Absent**
**None**

**Others Present**
**Dan Woods,** CEO
**Theresa Fuentes**, CLO
**Mark Klein**, CCMO
**Jon Cowan,** Executive Director, Government Relations and Community Partnerships
**Tim Daubert**, Director Community Partnerships
**Stephanie Cash**, ECH District Population Health Program Manager**

**Others Present**
**Tracy Fowler,** Director, Governance Services
**Gabriel Fernandez**, Governance Services Coordinator
**Brian Richards**, Audio Visual Services Program Manager

***Via teleconference*

| Agenda Item | Comments/Discussion | Approvals/ Action |
|---|---|---|
| **1. CALL TO ORDER/ ROLL CALL** | Chair Zoglin called to order the open session of the Regular Meeting of the El Camino Healthcare District Board of Directors (the "Board") at 5:30 p.m. and reviewed the logistics for the meeting. A verbal roll call was taken; Directors Fung, Miller, Ting, and Zoglin were present, constituting a quorum. Director Somersille joined at 5:32 p.m. | ***Call to Order at 5:31 p.m.*** |
| **2. CONSIDER AB 2449 REQUESTS** | Chair Zoglin asked if any members of the Board were appearing remotely per AB 2449. All directors were present in person. | |
| **3. SALUTE TO THE FLAG** | Chair Zoglin asked Director Fung to lead the Pledge of Allegiance. | |
| **4. POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Chair Zoglin asked if any Board members had a conflict of interest with any of the items on the agenda. No conflicts were noted. | |
| **5. PUBLIC COMMUNICATION** | Chair Zoglin asked if there were any members of the public with comments for any items not listed on the agenda. There were no members of the public requesting to speak. | |
| **6. FY27 COMMUNITY BENEFIT PLAN PRELIMINARY DISCUSSION** | Mr. Cowan provided brief introductory remarks, noting that this discussion was scheduled earlier in the fiscal year to obtain Board feedback on the maximum Community Benefit funds that may be available for FY27. He summarized the three scenarios and staff recommendation included in the packet.<br><br>Chair Zoglin reviewed the discussion process and reminded the Board that the randomizer would be used to determine speaking order. The sequence for this item was: Ting, Miller, Zoglin, Somersille, and Fung.<br><br>Director Miller inquired about the staffing levels underlying the projected District operating expenses reflected in the scenarios. Mr. Cowan confirmed that the Community Partnerships team consists of five staff members, and that the staffing level is expected to remain | ***Actions:*** *Staff to return in February 2026 meeting with clarification on prior year unspent funds; balance sheet implications; a framework for balancing support for underserved and the broader community* |

| | | |
|---|---|---|
| | stable through FY27, though additional temporary support may be needed should grant volume increase significantly.<br><br>Chair Zoglin referenced the historical overview in the packet and observed that the District has underspent its Gann-limit-allowable funds by approximately $10 million over the past five years. He commented that while the District is not required to spend the full amount of available tax revenue, the Board may wish to consider whether unspent funds could be deployed over the next several years to support community need. He expressed overarching support for being as aggressive as possible in establishing the FY27 ceiling, while maintaining the District's standards for grant review and approval.<br><br>Vice Chair Somersille expressed support for the maximum-growth scenario and noted that some grant recipients return funds each year when milestones are not met. She stated that, given the District's accumulated unspent funds, the Board should consider setting the highest ceiling.<br><br>Director Fung asked whether new community services, including potential clinical services, could be funded through Community Benefit. Mr. Cowan confirmed there are no exclusions so long as the expenditure aligns with program criteria. Director Fung noted he would revisit this topic with examples at a future meeting.<br><br>Director Ting emphasized the importance of maintaining flexibility regarding the use of accumulated reserves and noted that the Board must balance serving the underserved with meeting the needs of the broader District population.<br><br>Following discussion, Chair Zoglin requested that staff return in February 2026 with:<br>(1) clarification regarding prior-year unspent funds and potential balance-sheet options;<br>(2) additional framing on how to balance services for underserved populations and the broader District community; and<br>(3) updated information to support determining the FY27 maximum funds available. | |
| **7. ECHD POPULATION HEALTH UPDATE** | focuses on preventing chronic illness within the District through risk screening, awareness, and targeted interventions. He highlighted the progress to date, including development of the Prediabetes Risk Awareness Campaign, vendor selection and implementation of the Virtual Dietitian program (Season Health), and the phased product-development approach that will begin with an initial launch later this calendar year.<br><br>Chair Zoglin announced the randomized speaking order for this item as: Fung, Zoglin, Somersille, Ting, and Miller.<br><br>Director Fung had no initial questions. | ***Actions:*** *Return in February 2026 with more specific goals and KPIs for the Prediabetes / chronic-disease prevention initiative. Ensure* |

| | | |
|---|---|---|
| | Chair Zoglin asked how program awareness will be measured and emphasized the importance of establishing clear KPIs to ensure responsible use of taxpayer funds. He encouraged staff to sharpen the proposed metrics, consider additional indicators, and engage the Chief Clinical and Medical Officer to support the evaluation framework.<br><br>Vice Chair Somersille commended staff for focusing on early process measures and asked about the selection of MacKenzie as the vendor for the awareness campaign. Mr. Cowan shared that MacKenzie had completed similar work in the Bay Area and was chosen following a rigorous RFP process. Vice Chair Somersille noted the importance of designing the campaign to support knowledge and behavior change and referenced comparable public-health efforts.<br><br>Director Ting expressed support for the pioneering nature of the program and encouraged staff to plan for data collection and analysis to enable future publication of findings. He emphasized the importance of demonstrating measurable value.<br><br>Director Miller praised the quality of the materials and asked for additional detail regarding the use of consultants and whether the program's tools and applications would be free to participants, including uninsured individuals. Mr. Cowan confirmed that there would be no cost to participants and that uninsured individuals would receive at least one visit through the program. Director Miller requested that staff return with mid-year metrics.<br><br>Additional Board comments included encouragement to convene existing grantees so that related work is not conducted in silos, recognition of the District's trailblazing approach to chronic-disease prevention, and the importance of holistic evaluation across partner organizations.<br><br>At the conclusion of the discussion, Chair Zoglin requested that staff return in February 2026 with more specific goals and KPIs for the campaign and that the semi-annual metrics update be presented at the March 2026 meeting. | *involvement of Marketing in developing KPIs for the awareness campaign.*<br><br>*Return in March 2026 with the semi-annual Population Health update, including performance metrics.*<br><br>*Incorporate a literature review and consider potential publishing opportunities.* |
| **8. ECHD BOARD TERM LIMITS** | Director Miller thanked Ms. Fuentes and her team for the comprehensive background materials and noted that external advisors, including SpencerStuart, as well as some Hospital Board members, raised the question of whether the District Board should consider adopting term limits. She stated that the purpose of tonight's discussion was to hear initial perspectives from each Director, with the intention to return in February 2026 for a decision regarding whether to pursue a ballot measure.<br><br>The randomizer order of discussion was: Ting, Fung, Somersille, Zoglin, and Miller. | ***Actions:*** *Staff to include item on February 2026 agenda with (1) the administration's position on term limits; (2) any additional requested* |

| | | |
|---|---|---|
| | Director Ting remarked that he has reflected on the topic for some time. He acknowledged that while term limits may be beneficial in certain governmental contexts, the steep learning curve and complexity of healthcare district governance make continuity valuable. He emphasized the need to balance the benefits of fresh perspectives with the importance of retaining experienced Directors.<br><br>Director Fung thanked staff for the materials and noted that no healthcare district board in California currently has term limits. He commented that District boards are typically low-politics, highly technical, and mission-driven bodies, and that it took him a full term to become fully effective. He expressed concern that imposing term limits could result in the loss of Directors at their peak effectiveness and noted the challenges of recruiting qualified candidates. Director Fung also stated his belief that the hospital administration may feel more secure with a stable District Board, and he requested that staff include the administration's perspective on this question when the item returns in February.<br><br>Vice Chair Somersille stated that the concept of an imbalance of power had not been evident from her experience on the Board. She underscored the value of institutional knowledge and encouraged a thoughtful, data-informed approach.<br><br>Chair Zoglin commented that he remains open-minded but is currently leaning against imposing term limits. He acknowledged the benefits of board renewal while noting the risk of losing experienced governance leaders. He also referenced the potential timing options, including placement on the 2026 or 2028 ballot.<br><br>Director Miller noted that term limits would not affect current Directors immediately, as implementation would be prospective and staggered. She highlighted the importance of weighing the benefits of new perspectives against the need to maintain continuity and encouraged Directors to consider the long-term needs of the enterprise rather than personal preferences.<br><br>Following discussion, Chair Zoglin confirmed that staff will return in February 2026 with:<br>(1) the administration's position on term limits (as requested by Director Fung);<br>(2) any additional requested information; and<br>(3) the item listed as an action item for potential Board direction. | *information; and*<br>*(3) the item listed as a motion item for Board vote.* |
| **9. ECHD BOARD PRIORITIES AND PACING** | Chair Zoglin introduced the item and invited Directors to identify potential topics for inclusion in the Board's pacing calendar.<br><br>Vice Chair Somersille requested that the Board schedule a broader discussion regarding real estate, noting that it would be helpful for the District Board to understand its role and expectations in this area. She also expressed interest in the Board establishing a clearer | ***Actions:***<br>*Update pacing plan with the following:*<br>*Real Estate discussion in February* |

| | | |
|---|---|---|
| | purpose statement and recommended engaging a consultant to support that effort.<br><br>Director Miller agreed that developing a purpose statement would be beneficial but expressed that the Board should be able to conduct this work without hiring a consultant, preferring that the effort be completed internally.<br><br>Director Fung recommended that the Board undertake a discussion on District strategy, emphasizing that such a review should extend beyond the use of Community Benefit funds and should consider the District's broader responsibilities in coordination with the Hospital's strategic direction.<br><br>Director Ting supported revisiting the District's broader role and function, noting that the question of "what the District should be doing" should be examined periodically. He commented that the Board's role can become unclear ("nebulous") without intentional, recurring discussion.<br><br>Following discussion, Chair Zoglin proposed that he and Vice Chair Somersille work together to draft a proposed purpose statement for the District Board and bring it to the February 2026 meeting for consideration. The Board expressed support for this approach. | *Healthcare District Strategy Discussion.*<br><br>*Directors Zoglin and Somersille to work on District Purpose Statement. Add to January agenda review meeting.* |
| **10. FY26 ECHB DIRECTOR REAPPOINTMENT AD HOC COMMITTEE VERBAL UPDATE** | Vice Chair Somersille provided a brief update on the FY26 ECHB Director Reappointment Ad Hoc Committee. She reported that the Committee will meet with Director Doiguchi prior to the next District Board meeting and will bring its recommendations to the December 2025 meeting. | |
| **11. RECESS TO CLOSED SESSION** | **Motion:** To recess to closed session at 6:48 p.m.<br><br>**Movant:** Miller<br>**Second**: Ting<br>**Ayes:** Fung, Miller, Somersille, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | ***Recessed to closed session at 6:48 p.m.*** |
| **12. AGENDA ITEM 15: CLOSED SESSION REPORT OUT** | The open session was reconvened at **7:32 p.m.** by Chair Zoglin. Agenda Items 12–13 were addressed in closed session.<br><br>Mr. Fernandez reported that during closed session, the ECHD Board approved the closed session minutes of the October 14, 2025, meeting. No other reportable actions were taken. | ***Reconvened open session at 7:32 p.m.*** |
| **13. AGENDA ITEM 16: CONSENT CALENDAR** | Chair Zoglin asked if any items should be removed from the consent calendar for separate discussion. Vice Chair Somersille and Chair Zoglin requested that item (a) *Minutes of the Open Session of the District Board Meeting (10/14/2025*) be removed. Chair Zoglin invited Vice Chair Somersille to proceed with her comments. | ***Consent calendar approved.***<br>*- Minutes of the Open Session of the District Board Meeting* |

| | | |
|---|---|---|
| | Vice Chair Somersille requested that the minutes be amended to include her comments regarding the process for selecting experts. Chair Zoglin added that he had also requested an edit to ensure that the summary of item 13 (newsletter) reflected the process previously suggested and agreed upon.<br><br>Vice Chair Somersille read the suggested edits aloud, and both Directors confirmed that the revised language accurately reflected the Board's prior discussion.<br><br>**Motion:** To approve the consent calendar item (a) Minutes of the Open Session of the District Board Meeting (10/14/2025) as amended.<br><br>**Movant:** Somersille<br>**Second**: Ting<br>**Ayes:** Fung**,** Miller, Somersille, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | *(10/14/2025) as amended*<br>*- Received ECHD Sponsorships (July – October)*<br>*- Received FY26 YTD Financials*<br>*- Received FY26 Pacing Plan*<br>*- Proposed Revisions to Amended and Restated Bylaws for El Camino Hospital as approved by the El Camino Hospital Board on November 12, 2025 were approved.* |
| **14. AGENDA ITEM 17: BOARD ANNOUNCMENTS** | Director Miller reported that she recently attended her annual tobacco serialization meetings and shared that she had been re-elected as chair of one board (Santa Clara County Tobacco Securitization Corporation Board of Directors) and vice president of another (Silicon Valley Tobacco Securitization Authority Board of Directors). She noted that the upcoming year may be challenging due to efforts to pay down debt on one of the boards, with the county anticipating a significant financial impact.<br><br>No other announcements were made. | |
| **15. AGENDA ITEM 18: ADJOURNMENT** | **Motion**: To adjourn at 7:00 p.m.<br><br>**Movant:** Ting<br>**Second**: Fung<br>**Ayes:** Fung, Miller, Somersille, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | ***Meeting adjourned at 7:00 p.m.*** |

**Attest as to the approval of the foregoing minutes by the Board of Directors of El Camino Healthcare District:**

_____
Julia Miller
Secretary/Treasurer, ECHD Board

Prepared by: Tracy Fowler, Director, Governance Services
Reviewed by: Julia Miller, Secretary/Treasurer, ECHD Board and Theresa Fuentes, Chief Legal Officer

# El Camino Healthcare District Board of Directors
# Open Session Meeting Minutes
# Wednesday, December 10, 2025

Los Altos Country Club, Meeting Room Sequoia, 1560 Country Club Dr, Los Altos, CA 94024

**Board Members Present**
**John Zoglin**, Chair
**Julia E. Miller,** Secretary/Treasurer
**Peter C. Fung, MD**
**George O. Ting, MD**

**Others Present**
**Dan Woods,** CEO
**Theresa Fuentes**, CLO
**Mark Klein**, CCMO

**Others Present**
**Tracy Fowler,** Director, Governance Services
**Gabriel Fernandez**, Governance Services Coordinator

**Board Members Absent**
**Carol A. Somersille, MD,** Vice Chair

| Agenda Item | Comments/Discussion | Approvals/ Action |
|---|---|---|
| **1. CALL TO ORDER/ ROLL CALL** | Chair Zoglin called to order the open session of the Regular Meeting of the El Camino Healthcare District Board of Directors (the "Board") at 5:05 p.m. A verbal roll call was taken; Directors Fung, Miller, Ting, and Zoglin were present, constituting a quorum. Director Somersille was absent. | ***Call to Order at 5:05 p.m.*** |
| **2. CONSIDER AB 2449 REQUESTS** | Chair Zoglin asked if any members of the Board were appearing remotely per AB 2449. All directors were present in person. | |
| **3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Chair Zoglin asked if any Board members had a conflict of interest with any of the items on the agenda. No conflicts were noted. | |
| **4. PUBLIC COMMUNICATION** | Chair Zoglin asked if there were any members of the public with comments for any items not listed on the agenda. There were no members of the public requesting to speak. | |
| **5. VERBAL UPDATE FROM FY26 ECHD AD HOC COMMITTEE REGARDING REAPPOINTMENT OF EL CAMINO HOSPITAL BOARD DIRECTORS** | Chair Zoglin provided a brief update on the status of the Ad Hoc Committee, noting that the committee had completed its review process and unanimously recommended reappointment following its review of candidate qualifications and Board needs.<br><br>**Motion:** To adopt Resolution 2025-09 appointing Wayne Doiguchi to the El Camino Hospital Board of Directors.<br><br>**Movant:** Fung<br>**Second**: Miller<br>**Ayes:** Fung, Miller, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: Somersille<br>**Recused**: None<br><br>**Motion:** To adopt Resolution 2025-10 appointing Bob Rebitzer to the El Camino Hospital Board of Directors.<br><br>**Movant:** Miller<br>**Second**: Fung<br>**Ayes:** Fung, Miller, Ting, Zoglin | ***Resolution 2025-09 was approved.***<br><br>***Resolution 2025-10 was approved.*** |

| | | |
|---|---|---|
| | **Noes**: None<br>**Abstentions**: None<br>**Absent**: Somersille<br>**Recused**: None | |
| **6. RECESS TO CLOSED SESSION** | **Motion:** To recess to closed session at 5:10 p.m.<br><br>**Movant:** Miller<br>**Second**: Fung<br>**Ayes:** Fung, Miller, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: Somersille<br>**Recused**: None | ***Recessed to closed session at 5:10 p.m.*** |
| **7. AGENDA ITEM 9: CLOSED SESSION REPORT OUT** | The open session was reconvened at 5:14 p.m. by Chair Zoglin. Agenda Item 8 was addressed in closed session.<br><br>Mr. Fernandez reported that during closed session, the ECHD Board took no reportable actions. | ***Reconvened open session at 5:14 p.m.*** |
| **8. AGENDA ITEM 10: ADJOURNMENT** | **Motion**: To adjourn at 5:15 p.m.<br><br>**Movant:** Miller<br>**Second**: Fung<br>**Ayes:** Fung, Miller, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: Somersille<br>**Recused**: None | ***Meeting adjourned at 5:15 p.m.*** |

**Attest as to the approval of the foregoing minutes by the Board of Directors of El Camino Healthcare District:**

_____
Julia Miller
Secretary/Treasurer, ECHD Board

Prepared by: Tracy Fowler, Director, Governance Services
Reviewed by: Julia Miller, Secretary/Treasurer, ECHD Board and Theresa Fuentes, Chief Legal Officer

# El Camino Healthcare District Board of Directors
## Site Visit Meeting Minutes
## Friday, December 12, 2025

**Living Classroom at Monta Loma Elementary School | 460 Thompson Ave., Sunnyvale, CA 94043**

**Board Members Present**
**John Zoglin,** Chair
**Carol A. Somersille, MD,** Vice Chair
**Julia E. Miller,** Secretary/ Treasurer
**George Ting, MD**

**Others Present**
**Jon Cowan,** Executive Director, Government Relations and Community Partnerships
**Gabriel Fernandez,** Coordinator, Governance Services
**Arielle Bonifacio Hernandez**, Sr. Community Partnerships Specialist

**Others Present (cont.)**
**Sierra Van Zandt,** Executive Director
**Patti Berryhill,** Lead Gardener
**Susan Harder,** Program Director
**Don Arnold,** Board Member

**Board Members Absent**
**Peter C. Fung, MD**

**Via teleconference*

| Agenda Item | Comments/Discussion | Approvals/ Action |
|---|---|---|
| **1. CALL TO ORDER/ ROLL CALL** | Chair Zoglin called to order the open session of the Special Site Visit Meeting of the El Camino Healthcare District Board of Directors (the "Board") at 3:34 pm and reviewed the logistics for the meeting. A verbal roll call was taken; Directors Miller, Somersille, Ting, and Zoglin were present, constituting a quorum. Director Fung was absent. | ***Meeting Called to Order at 3:34 pm.*** |
| **2. PUBLIC COMMUNICATION** | Chair Zoglin asked if there were any members of the public with comments for any items not listed on the agenda. There were no members of the public present. | |
| **3. BOARD AND TEAM INTRODUCTIONS** | Ms. Van Zandt introduced members of the Living Classroom staff to the District Board and accompanying El Camino Health staff. | |
| **4. SITE TOUR** | The Living Classroom staff a site tour of Ellis Elementary School. The Board observed the various outdoor gardens that students utilize, the curriculum provided, and the support that the El Camino Healthcare District provides. | |
| **5. GRANT PARTNER PRESENTATION** | Ms. Van Zandt and Ms. Harder delivered a presentation outlining the Living Classroom program's services and key metrics.<br>Staff presented an overview of their garden-based education program, which operates at 15 local schools, including all Mountain View Whisman School District campuses. Staff attributed the strong results to teacher engagement and increased student enrollment. The program features outdoor lessons, food tastings, and edible garden maintenance. Staff noted challenges in meeting targets for increasing daily fruit and vegetable consumption, citing implementation issues and survey limitations, and outlined steps being taken to address these areas. Staff continued to highlight high levels of student enjoyment and engagement, as well as the program's ongoing positive impact on healthy eating | |

| | | |
|---|---|---|
| | behaviors. The Board inquired about the program's growth and any plans to expand. The Living Classroom staff shared that they've received significant interest across the state in the program and are excited about future growth opportunities that will allow them to stay true to the program's mission. | |
| **6. DISCUSSION and Q&A** | The Board inquired about the program's growth and any plans to expand. The Living Classroom staff shared that they've received significant interest across the state in the program and are excited about future growth opportunities that will allow them to stay true to the program's mission. | |
| **7. ADJOURNMENT** | **Motion:** To adjourn at 4:21 pm<br><br>**Movant:** Miller<br>**Second**: Somersille<br>**Ayes:** Miller, Somersille, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: Fung<br>**Recused**: None | ***Meeting Adjourned at 4:21 pm*** |

**Attest as to the approval of the foregoing minutes by the Board of Directors of El Camino Healthcare District:**

_____
Julia Miller
Secretary/Treasurer, ECHD Board

Prepared by: Gabriel Fernandez, Governance Services Coordinator

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING COVER MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Theresa Fuentes, Chief Legal Officer
Deanna Dudley, CHRO
**Date:** February 10, 2026
**Subject:** ECHD Formal Record of Action – Health Benefits

**Purpose:** To approve El Camino Healthcare District Formal Record of Action adopting the El Camino Hospital Health and Welfare Plan ("Plan").

**Summary:**

California Government Code section 53200, et seq., permits board members of a healthcare district to participate in the organization's health and welfare benefits, and those benefits cannot be greater than the benefits received by all other employees of the organization. On February 8, 2023, the El Camino Healthcare District ("District") voted to offer health and welfare benefits to District board members in the same form and fashion as those provided to El Camino Hospital employees. As such, the District was added as a participating employer to the Plan.

To ensure appropriate documentation and regulatory compliance, the Plan Administrator has requested that the District Board approve and execute the attached Formal Record of Action.

**List of Attachments:**

1. ECHD Resolution 2026-02 El Camino Healthcare District Formal Record of Action
2. El Camino Hospital Health and Welfare Plan Wrap Plan Document (in Appendix)

**EL CAMINO HEALTHCARE DISTRICT**
**(ECHD) FORMAL RECORD OF ACTION**

**ECHD RESOLUTION 2026 - 02**

The following actions are hereby taken by the representatives of El Camino Healthcare District (ECHD) (the "District") who are authorized to take action on behalf of the District.

With respect to the adoption of the El Camino Hospital Health & Welfare Plan (the "Plan") sponsored by El Camino Hospital the following resolutions are hereby adopted:

**RESOLVED**: That the District hereby adopts the Plan;

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

Dated this 10th day of February, 2026.

_____
*Signature*

_____
*Julia Miller*

_____
*Secretary, El Camino Healthcare District*

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING COVER MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Jon Cowan, Executive Director Government Relations & Community Partnerships
**Date:** February 10, 2026
**Subject:** Community Benefit Sponsorships

**Purpose:**

To provide the Board with FY2026 ECHD Sponsorships in December 2025 – January 2026.

**Summary:**

1. Situation: Community Benefit Staff was asked to keep the Board informed regarding Community Benefit Sponsorships YTD.

2. Authority: Board reviewed and approved $90,000 for Sponsorships in the FY2026 Community Benefit Plan in June 2025.

3. Background:

- Sponsorship information and instructions are available on the District website.
- Requests include sponsorship packets that outline the event date, purpose, levels of sponsorship and requirements for sponsor acknowledgement. These requests are reviewed throughout the year on a rolling basis by Community Benefit Staff and the other designated departments that provide community sponsorships (*e.g.*, Marketing & Communications and Government Relations & Community Partnerships).
- Community Benefit-funded Sponsorships provide general support for health-related agencies improving the well-being of the community.
    - Community Benefit Sponsorships from December 1, 2025 – January 31, 2026 totaled **$0** (Sponsorships occur at different times throughout the year.)

# EL CAMINO HEALTHCARE DISTRICT
# FY2026 PACING PLAN / MASTER CALENDAR

| AGENDA ITEM | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN |
| **COMMUNITY BENEFIT** | | | | | | | | | | | | |
| Spotlight Recognition | | | | ✓ | | | | ✓ | ✓ | | | |
| CB Year-End Report | | | | ✓ | | | | | | | | |
| CBAC Policy – Annual Approval | | | | ✓ | | | | | | | | |
| CB Plan Study Session | | | | | | | | | | | ✓ | |
| CB Mid-Year Metrics | | | | | ✓ | | | | | | ✓ | |
| Approval of CB Plan | | | | | | | | | | | | ✓ |
| Grant Partner Site Visit | | | | ✓ | | ✓ | | ✓ | ✓ | | | |
| **COMPLIANCE** | | | | | | | | | | | | |
| Financial Audit – Consolidated ECH District Financials | | | | ✓ | | | | | | | | |
| Approve Hospital Audit | | | | ✓ | | | | | | | | |
| **DISTRICT REAL ESTATE** | | | | | | | | | | | | |
| Real Estate Update | | | | ✓ | | | | ✓ | ✓ | | | |
| District Capital Outlay | | | | | | | | | | | ✓ | ✓ |
| **EXECUTIVE PERFORMANCE** | | | | | | | | | | | | |
| CEO Performance Review | | | | ✓ | | | | | | | | |
| **FINANCE** | | | | | | | | | | | | |
| Financials | | | | ✓ | | | | ✓ | ✓ | | | ✓ |
| Budget | | | | | | | | | | | ✓ | ✓ |
| Tax Appropriation (Gann limit) | | | | | | | | | ✓ | | ✓ | ✓ |
| **GOVERNANCE** | | | | | | | | | | | | |
| Appoint FY27 Ad Hoc Committee & Advisors for ECHB Director Election | | | | ✓ FY27 | | | | | | | | |
| ECHB Director Ad Hoc Committee Update | | | | ✓ FY26 | ✓ FY26 | | | ✓ **FY27** | ✓ **FY27** | | ✓ **FY27** | |
| Appointment/Re-appointment of El Camino Hospital Board Director | | | | | | | | ~~✓ Incumbent FY26~~ | | | ~~✓ New FY26~~ | |
| Review Process for ECHD Board Officer Election (*Odd Years*) | | | | | | | | | | | | |
| ECHD Board Officer Election (*Odd Years*) | | | | | | | | | | | | |
| Appointment of Liaison to the Community Benefit Advisory Council | | | | | | | | | | | | ✓ |
| Pacing Plan & Meeting Dates | | | | | | | | | | | ✓ | ✓ |
| Oath of Office for Newly Elected/Re-elected Directors (*Even Years*) | | | | | | | | | | | | |
| Possible Appointment to ECHB Board for Newly Elected Directors (*Even Years*) | | | | | | | | | | | | |
| ECHD Board Self-Evaluation | | | | | | | | | | | | |
| ECHD Bylaws Review | | | | | | | | ✓ | | | | |
| **STRATEGY** | | | | | | | | | | | | |
| ECHD Strategy Discussion | | | | | | | | ✓ | | | | |
| Population Health Strategy Update | | | | ✓ | | | | ✓ | ✓ | | | |

*Updated 11/20/2025* **FY26 ECHB Appointment:** Doiguchi/Rebitzer **FY27 ECHB Appointment/Recruitment:** Watters/Chen

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING COVER MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** John Zoglin, Board Chair
Jon Cowan, Executive Director of Government Relations & Community Partnerships
**Date:** February 10, 2026
**Subject:** El Camino Healthcare District Board Site Visit Cadence

**Purpose:** To solicit feedback from the Board of Directors on their preferences for future El Camino Healthcare District (ECHD) Board site visits.

**Summary:**

The District Board Site Visits were established due to interest in balancing board members' governance role with gaining detailed insights which come from focusing on an individual grant partner. Site visits allow for an in-depth discussion of the accomplishments and challenges faced by the grantees. They allow for education and bring to life the richness of an organization's critical community health improvement work. For grantees, the site visits can provide an opportunity to learn more about the District Board's priorities and questions.

At the **June 2021 District Board meeting**, management committed to four District grantee site visits each fiscal year which board members could attend.

At the **September 2021 District Board meeting**, board members and management further aligned on the importance of holding time in advance that worked well for the Board. Board members were surveyed to find the day/time that worked best. Friday afternoon was the consensus due to work schedules at the time. Staff operationalized the site visits by holding four Friday afternoons between 2:00pm-5:00pm on calendars. Site visits typically lasted for 60 to 90 minutes, but this wider time window was held due to the operational constraints of different grantees. For example, schools preferred later times after students had left.

The quarterly site visits began on **December 3, 2021**, with the first visit at the LifeMoves Interim Housing Community. There have been sixteen District Board site visits through December 2025.

After four years, it is a good time to review the District Board's preferences for future site visits.

Authority: The Board will provide feedback on the objectives and approach for executing future site visits.

Outcomes: Management and staff will incorporate feedback before executing future site visits.

**Suggested Board Discussion Questions:**

1. Is the current structure of the site visits still meeting the District Board's objectives?
2. Are there different date, time, and frequency options that should be considered?

# EL CAMINO HOSPITAL HEALTH & WELFARE PLAN

# WRAP PLAN DOCUMENT

Amended and Restated Plan, Effective January 01, 2025

# EL CAMINO HOSPITAL HEALTH & WELFARE PLAN

## TABLE OF CONTENTS

Page

# EL CAMINO HOSPITAL HEALTH & WELFARE PLAN

## WRAP PLAN DOCUMENT

El Camino Hospital (the "Employer") hereby amends and restates the El Camino Hospital Health & Welfare Plan (the 'Plan'), in its entirety, effective as of January 01, 2025.

## ARTICLE I

## Purpose

The purpose of the Plan is to provide to Participants, and their Spouses, Dependents, and Beneficiaries certain welfare benefits described herein. Notwithstanding the number and types of benefits incorporated hereunder, the Plan is, and shall be treated as, a single welfare benefit plan to the extent permitted under ERISA. The Plan is intended to meet all applicable requirements of ERISA and the Code as amended, together with rulings and regulations promulgated thereunder.

## ARTICLE II

## Definitions

2.1 "ACA" means the Patient Protection and Affordable Care Act of 2010, as amended.

2.2 "Beneficiary" means a beneficiary as defined under a Welfare Program, which may include domestic partners.

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

2.4 "Dependent" means dependent as defined under a Welfare Program. However, for purposes of any group health plan listed in Appendix A that provides medical benefits (other than a retiree medical plan) and other Welfare Programs that provide medical benefits, a Dependent shall include a Participant's eligible children who have not attained age 26 (or such later age as determined by the Plan Administrator) and, for Grandfathered Plans, prior to Plan Years beginning before January 1, 2014, who are not eligible to enroll in another employer's medical plan, other than the medical plan of a parent.

2.5 "Effective Date" means January 01, 2025, as herein amended and restated.

2.6 "Employee" means any person providing services to the Employer or a Participating Employer as a common-law employee. To the extent permitted by law, independent contractors (even if re-characterized by the Internal Revenue Service as employees), leased employees within the meaning of Section 414(n) of the Code, and individuals designated by the Employer or Participating Employer as temporary employees shall not be Employees for purposes of this Plan. For purposes of any group health plan incorporated herein, the term

Employee shall include any variable hour, temporary or seasonal employees defined as a full-time employee under the ACA.

2.7 "Employer" means El Camino Hospital, and any entity which succeeds to the business and assumes the obligations of the Employer hereunder.

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

2.9 "Former Employee" means any person formerly employed as an Employee.

2.10 "Grandfathered Plan" means the term as it is defined in the Department of Labor Regulations, 29 C.F.R. § 2590.715-1251.

2.11 "Leave of Absence" means a personal leave, medical leave or military leave, as approved by the Employer.

2.12 "Participant" means any Employee or Former Employee who satisfies the requirements of Article III of the Plan, has chosen to participate in the Plan and whose participation has not terminated in accordance with Section 3.3.

2.13 "Participant Contribution" means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term "Participant Contribution" includes contributions used for the provision of benefits under a self-insured arrangement of the Employer as well as contributions used to purchase insurance contracts or policies.

2.14 "Participating Employer" means any member of the following group including the Employer, if such member adopts the Plan with the Employer's authorization as provided in Section 10.1: (i) a controlled group of corporations, within the meaning of Section 414(b) of the Code; (ii) a group of trades or businesses under common control, within the meaning of Section 414(c) of the Code; (iii) an affiliated service group, within the meaning of Section 414(m) of the Code; or (iv) a trade or business required to be aggregated pursuant to Section 414(o) of the Code. Each Participating Employer is identified in Appendix B. The Employer shall amend Appendix B as needed, to reflect a Participating Employer's adoption of the Plan or withdrawal from the Plan, without any need to otherwise amend the Plan. Amendment of Appendix B may be made by any authorized officer or representative of the Employer and shall not require approval of the Board of Directors.

2.15 "Plan" means the El Camino Hospital Health & Welfare Plan, as set forth herein and each Welfare Program incorporated hereunder by reference, as amended from time to time.

2.16 "Plan Administrator" means the Employer or such other individual, committee or firm as the Employer shall designate from time to time.

2.17 "Plan Year" means the twelve consecutive month period ending on December 31.

2.18 "Spouse" means a spouse as defined under a Welfare Program. Notwithstanding anything to the contrary contained herein, the term "Spouse" shall include a same-sex spouse who is legally married under applicable law.

2.19 "Welfare Program" means a written arrangement incorporated into this Plan that is offered by the Employer which provides an employee benefit, including those that would be treated as an "employee welfare benefit plan" under Section 3(l) of ERISA if offered separately. Welfare Program also means any plan established pursuant to Section 125 or Section 132(f) of the Code. Each Welfare Program under the Plan is identified in Appendix A which is incorporated into and a part of the Plan. The documents for each Welfare Program are incorporated into this document. The Employer may add or delete a Welfare Program from the Plan by amending Appendix A, without any need to otherwise amend the Plan. Amendment of Appendix A may be made by any authorized officer or representative of the Employer and shall not require approval by the Employer's Board of Directors.

In the event that the provisions of any Welfare Program conflict with or contradict the provisions of this document or any other Welfare Program, the Plan Administrator shall use its discretion to interpret the terms and purpose of the Plan, including the written terms and provisions of any Welfare Program document, so as to resolve any conflict or contradiction. However, the terms of this document may not enlarge the rights of a Participant, Spouse, Dependent or Beneficiary to benefits available under any Welfare Program.

## ARTICLE III

## Eligibility and Participation

3.1 Eligibility. (a) An Employee shall be eligible to participate in the Plan only as specified in a particular Welfare Program listed in Appendix A. An eligible Employee does not include any individual who is in a division, department, unit, or job classification designated by the Employer as not benefit-eligible, regardless of the Employee's work schedule or number of hours worked, unless the Employee is included in the employer shared responsibility penalty calculations, as defined under the ACA, and the Plan Administrator elects to include such Employees as Eligible Employees. The Welfare Program may also designate those Spouses, Dependents, Domestic Partners or Beneficiaries, if any, eligible to receive benefits from the Plan and set forth the criteria for their becoming covered hereunder.

(b) If the Employer has the equivalent of 50 or more full-time Employees, to the extent required by the ACA and other applicable federal law, an Employee shall be eligible to participate in the Employer's group health plan if, in addition to meeting other applicable criteria, the Employee is a full-time Employee who is employed an average of at least 30 hours of service per week with the Employer.

Full-time Employee status for group health plan coverage purposes will be determined in accordance with the measurement rules as specified by the federal government and as adopted by the Employer for all Employees (including variable hour, temporary and seasonal

employees, if such classes exist within the Employer). Full-time Employee status does not include any temporary employee who is eligible for group health plan coverage through a leasing organization, unless otherwise required by the ACA and the Employer. Determination of full-time Employee status will be made by the Plan Administrator, in its sole and absolute discretion, in accordance with the Plan and the Employer Shared Responsibility provisions of the ACA.

3.2 Enrollment. The Plan Administrator shall establish procedures in accordance with the Welfare Programs for the enrollment of eligible Employees, their Spouses or Dependents, if any, under the Plan. The Plan Administrator shall prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

3.3 Termination of Participation. A Participant shall cease being a Participant in the Plan and coverage under this Plan for the Participant, his or her Spouse, Dependents and Beneficiaries, if any, shall terminate in accordance with the provisions of the Welfare Programs and the ACA.

## ARTICLE IV

## Funding and Benefits

4.1 Funding. (a) Notwithstanding anything to the contrary contained herein, participation in the Plan and the payment of Plan benefits attributable to Employer or Participating Employer contributions shall be conditioned on a Participant contributing to the Plan at such time and in such amounts as the Plan Administrator shall establish from time to time ("Participant Contribution"). The Plan Administrator may require that any Participant Contributions be made by payroll deduction. Nothing herein requires the Employer, Participating Employer or the Plan Administrator to contribute to or under any Welfare Program, or to maintain any fund or segregate any amount for the benefit of any Participant, Spouse, Dependent, Domestic Partners or Beneficiary, except to the extent specifically required under the terms of a Welfare Program. No Participant, Spouse, Dependent, Domestic Partners or Beneficiary shall have any right to, or interest in, the assets of the Employer or Participating Employer.

(b) The Employer shall have no obligation, but shall have the right, to insure or reinsure, or to purchase stop loss coverage with respect to any Welfare Program under this Plan. To the extent the Employer elects to purchase insurance with respect to any Welfare Program, any benefits to be provided under such Welfare Program shall be the sole responsibility of the insurer, and the Employer or Participating Employer shall have no responsibility for the payment of such benefits (except for refunding any Participant Contributions that were not remitted to the insurer). Except as otherwise permitted by rulings or regulations under ERISA, any Participant Contributions shall be remitted to the appropriate insurer, as soon as practicable but not later than 90 days after such contributions are made and would otherwise have been paid to Participants in cash.

(c) If an insurer, health maintenance organization, pharmacy benefit manager or other party pays any rebate (including any medical loss ratio rebate pursuant to the ACA),

allowance, credit, or other amount with respect to the Plan or an insurance policy relating to a Component Document (a "Recovery"), whether such Recovery be paid in cash or effected as a credit against future premium or similar payments in the current or ensuing year, the Recovery amount will not be an asset of the Plan, but instead will be retained by the Employer as part of the Employer's general assets, except as provided below or as otherwise may be required by law. Therefore, a Recovery will not reduce or offset contributions or other amounts paid by Employees (or Dependents) for coverage under the Plan and will not otherwise be shared with Employees (or Dependents). If a Recovery exceeds the total amounts paid by the Employer for medical coverage under the Plan for the relevant period, the excess amount may not be retained by the Employer but instead will be treated as an asset of the Plan to the extent required by applicable law.

4.2 Benefits. Benefits will be paid solely in the form and amount specified in the relevant Welfare Program and pursuant to the terms of such Welfare Program.

## ARTICLE V

## Plan Administration and Fiduciary Duties

5.1 Named Fiduciary. The Plan Administrator shall be the "named fiduciary" of the Plan, as defined in Section 402(a)(2) of ERISA, unless the Employer appoints a replacement.

5.2 Plan Administration. Except as otherwise provided in a Welfare Program:

(a) The Plan Administrator shall have sole discretion and authority to control and manage the operation and administration of the Plan.

(b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:

(i) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;

(ii) To prepare and distribute information explaining the Plan to Participants;

(iii) To receive from the Employer (or Participating Employer) and Participants, Spouses, Dependents and Beneficiaries such information as shall be necessary for the proper administration of the Plan;

(iv) To keep records of elections, claims, disbursements for claims under the Plan, and any other information required by ERISA or the Code;

(v) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents it deems advisable;

(vi) To purchase any insurance deemed necessary for providing benefits under the Plan;

(vii) To accept, modify or reject Participant elections under the Plan;

(viii) To promulgate election forms and claims forms to be used by Participants;

(ix) To prepare and file any reports or returns with respect to the Plan required by the Code, ERISA or any other laws;

(x) To determine and announce any Participant Contributions required hereunder;

(xi) To determine and enforce any limits on benefits elected hereunder;

(xii) To take such action as may be necessary to cause any required payroll deduction of any Participant Contributions required hereunder; and

(xiii) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant, Spouse, Dependent or Beneficiary, in whatever manner the Plan Administrator determines is appropriate, including recoupment of past payments, or offsets against, future payments due that Participant, Spouse, Dependent or Beneficiary.

5.3 Delegation of Duties. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan, may designate fiduciaries other than those named in the Plan, and may allocate or reallocate fiduciary responsibilities under the Plan.

5.4 Indemnification. The Plan Administrator and any delegate who is an employee of the Employer or Participating Employer shall be fully indemnified by the Employer and each Participating Employer against all liabilities, costs, and expenses (including defense costs, but excluding any amount representing a settlement unless such settlement is approved by the Employer) imposed upon it in connection with any action, suit, or proceeding to which it may be a party by reason of being the Plan Administrator or having been assigned or delegated any of the powers or duties of the Plan Administrator, and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

5.5 Fiduciary Duties and Responsibilities. Each Plan fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of each Participant, Spouse, Dependent and Beneficiary; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan; and in accordance with the terms of the Plan. Each fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in exercising such authority. A fiduciary may serve in more than one fiduciary capacity. Unless liability is otherwise provided under Section 405 of ERISA, a named fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

## ARTICLE VI

## Claims and Subrogation

6.1 Claims Procedure. Except as provided in Sections 6.2, 6.3 and 6.4, a claim for benefits under a Welfare Program shall be submitted in accordance with and to the party designated under the terms of such Welfare Program.

6.2 Claims Procedures for Group Health Plans. (a) This Section is intended to comply with Department of Labor Regulations, 29 C.F.R. §§ 2560.503-1 and 2590.715-2719, and shall apply specifically to claims under a group health plan as defined in Department of Labor Regulation 29 C.F.R. § 2560.503-1. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program, the claims procedure in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure, provided such other claims procedure complies with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719. In accordance with those regulations, all claims and appeals for group health plan benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Notwithstanding any provision of this Article VI, a group health plan that is a Grandfathered Plan is not subject to the claims and appeals procedures under Department of Labor Regulation § 2590.715-2719.

(b) Written Claim for Benefits. If a claimant asserts a right to any benefit under the Plan, the claimant must file a written claim for such benefit with the Plan Administrator. For purposes of this Section, claimant shall mean any Participant, Spouse, Dependent, or Beneficiary or authorized representative who files a claim for group health plan benefits under the Plan.

(c) Benefit Determinations. All adverse benefit determinations referenced below shall be written in a culturally and linguistically appropriate manner, and shall include the

information required by Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(i) Post-Service Claims. A post-service claim is any claim that is filed for payment of benefits after health care has been received.

(A) Upon the denial of a post-service claim, the Plan Administrator shall notify the claimant in writing of such denial within 30 days of receipt of the claim. The Plan Administrator shall be permitted one 15-day extension to the 30-day claim determination period, provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan's control and notifies the claimant before the end of the initial 30-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to render a decision. If such extension is required due to the claimant's failure to submit all information necessary to decide the claim, the extension notification must specifically describe the required information and the claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim.

(B) A denial notice shall explain the reason(s) for denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(C) The time period to consider a post-service claim shall be suspended from the date any notification of extension is sent to the claimant until the claimant fulfills any request for additional information.

(ii) Pre-Service Claims. A pre-service claim is any claim for benefits that requires certification or approval prior to the performance of the requested health care service.

(A) Upon receiving a pre-service claim, the Plan Administrator shall notify the claimant in writing of the Plan's benefit determination within a reasonable period but no later than 15 days after receipt of the claim. The Plan Administrator shall be permitted one 15-day extension provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan Administrator's control and notifies the claimant before the end of the initial 15-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to render a decision. The Plan Administrator shall, within 5 days of receiving any deficient claim, notify the claimant of such deficiency and the steps necessary to correct the claim. Notification may

be oral unless the claimant requests written notification. The claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim.

(B) A denial notice shall explain the reason(s) for the denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(C) The time period to consider a pre-service claim shall be suspended from the date any notification of extension is sent to the claimant until the claimant fulfills any request for additional information.

(iii) Urgent Care Claims. An urgent care claim is a claim that requires notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize the claimant's life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of the claimant's health condition, could cause severe pain.

(A) An urgent care claimant shall receive notice of the benefit determination in writing or electronically as soon as possible, but no later than 72 hours (or such other time as prescribed in Department of Labor Regulations) after the Plan Administrator receives all necessary information, taking into account the severity of the claimant's condition. Notice of denial may be oral with a written or electronic confirmation to follow within 3 days. If the claimant files an urgent care claim improperly, the Plan Administrator, within 24 hours after the claim is received, shall notify the claimant of the improper filing and how to correct it. The claimant shall have 48 hours (or such other time as prescribed in Department of Labor Regulations) to provide the requested information and shall be notified of a determination no later than 48 hours after receipt of the corrected claim or the end of the 48-hour period afforded to the claimant to provide the requested additional information.

(B) A denial notice shall explain the reason(s) for the denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(iv) Concurrent Care Claims.

(A) Any request by a claimant to extend an on-going course of treatment beyond a previously approved specified period of time or number of treatments, that is an urgent care claim as defined in paragraph (iii), shall be decided as soon as possible, and the Plan Administrator shall notify the claimant of the determination within 24 hours of receipt of the claim, provided the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments. If the claimant's request for extended urgent care treatment is not made at least 24 hours prior to the end of the approved treatment, the request shall be treated as an urgent care claim in accordance with paragraph (iii).

(B) If an on-going course of treatment was previously approved for a specified period of time or number of treatments, and the claimant's request to extend treatment is non-urgent, the claimant's request shall be considered a new claim and decided in accordance with post-service or pre-service timeframes, as applicable.

(d) Appeal of Claim Denial.

(i) Any claimant shall have the right to appeal an "adverse benefit determination" as defined in Department of Labor Regulation 29 C.F.R. § 2590.715-2719 within 180 days of receipt of such adverse benefit determination. Any appeal shall be submitted to the Plan Administrator in writing. If the appeal relates to a claim for payment, the claimant's request should include: the patient's name and plan identification number; the date(s) of health care service(s); the provider's name; the reason(s) the claimant believes the claim should be paid; and any documentation or other written information to support the claimant's request for claim payment.

(ii) An appeal shall be determined by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor a subordinate of that individual. If the appeal is related to medical matters, the appeal shall be reviewed in consultation with an independent and impartial health care professional who has appropriate training and experience in the particular field of medicine in order to make the health care judgment and who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, independent and impartial medical experts as part of the appeal resolution process. The claimant consents to this referral and the sharing of pertinent health claim information. The claimant shall have the right to review and respond to any new or additional evidence or rationales considered, relied upon, or generated by the Plan or other person making the benefit determination before the Plan issues an adverse benefit determination on appeal. Upon request and free of charge the claimant has the right to reasonable access to and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(iii) The claimant shall be notified of the Plan Administrator's decision upon review as appropriate, in accordance with the content and timing requirements of Department of Labor Regulations, 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(iv) Upon being notified of an adverse determination under an appeal, the claimant shall be permitted, within 60 days of receiving notice of such determination, to submit notice of a "second-level appeal" to the Plan Administrator. A second-level appeal shall be decided in accordance with the rules in paragraph (ii).

(e) Timeframes for Appeals Determinations.

(i) Pre-Service Claim Appeal. The Plan Administrator shall have 15 days, upon receiving notice of appeal (or second-level appeal) of the denial of benefits under a pre-service claim, to notify the claimant electronically or in writing of the appeal determination.

(ii) Post-Service Claim Appeal. The Plan Administrator shall have 30 days, upon receiving notice of appeal (or second-level appeal) of the denial of benefits under a post-service claim, to notify the claimant electronically or in writing of the appeal determination.

(iii) Urgent Care Claim Appeal. Upon receiving a notice to appeal (or second-level appeal) the determination of a claim involving urgent care, the Plan Administrator shall notify the claimant of the appeal determination as soon as possible, taking into account medical exigencies surrounding the claim, but no later than 72 hours (or such other time as prescribed in Department of Labor Regulations). Notice shall be given to the claimant by telephone, facsimile, or other similarly expeditious manner. Oral communications shall be followed up in writing.

(iv) The Plan Administrator has the exclusive right to interpret and administer the provisions of the Plan and its decisions with respect to claims are conclusive and binding.

(f) External Appeals. Except as otherwise required by applicable law, if a Participant exhausts all internal appeals procedures, the Participant may commence an external review. The external review process will comply with applicable state or federal law and other rules and procedures for non-Grandfathered Plans as prescribed in Department of Labor Regulation 29 C.F.R. § 2590.715-2719.

6.3 Claims Procedure for Benefits Based on Determination of Disability. (a) This Section shall apply to any claim made under a Welfare Program which bases benefits on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program, the claims procedure in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure as long as such other claims procedure complies with Department of Labor Regulation 29 C.F.R. § 2560.503-1. In accordance with that regulation, all claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

(b) If a claim for benefits based on a determination of disability is denied in whole or in part, the claimant or the claimant's Beneficiary shall receive written notification of the "adverse benefit determination" as defined in 29 C.F.R. § 2560.503-1 in a culturally and linguistically appropriate manner. A denial notice shall explain the reason(s) for the denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in

Department of Labor Regulation 29 C.F.R. § 2560.503-1. Among other requirements, that regulation requires denial notices for disability claims to include:

(i) a discussion of the decision, including, if applicable, the basis for disagreeing with or not following the views of health care and vocational professionals who evaluated the claimant, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, or with a disability benefit determination regarding the claimant made by the Social Security Administration;

(ii) the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

(iii) if applicable, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iv) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Claimants will receive adverse benefit determinations within a reasonable period of time, but no later than 45 days after the Plan Administrator's receipt of the claim. The Plan Administrator may extend this period for up to 30 additional days provided the Plan Administrator determines that the extension is necessary due to matters beyond the Plan Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Plan Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Plan Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. Any notice of extension must be sent to the claimant before the end of the initial 30-day period, and shall explain the circumstances requiring the extension, the date by which the Plan Administrator expects to render a decision, the standards on which the claimant's entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, the claimant must submit. The claimant shall be provided with at least 45 days to provide the additional information. The period from which the claimant is notified of the additional required information to the date the claimant responds is not counted as part of the determination period.

(c) The claimant shall have 180 days to appeal an adverse benefit determination. The claimant shall have the right to review and respond to any new or additional evidence or rationales considered, relied upon, or generated by the Plan or other person making the benefit determination before the Plan issues an adverse benefit determination on appeal. The claimant shall be notified of the Plan Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Plan Administrator receives the claimant's appeal request. The Plan's adverse benefit determination on review shall include the information

required by Department of Labor Regulation 29 C.F.R. § 2560.503-1. Among other requirements, this adverse benefit determination must include a statement of the claimant's right to bring a lawsuit in federal court and a description of any applicable contractual limitations period that applies to the claimant's right to bring a lawsuit and its expiration date.

The 45-day period may be extended for an additional 45-day period if the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time and provided that the claimant is notified of the extension prior to the expiration of the initial 45-day period. Such notice shall state the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

(d) The time period to consider a claim for benefits based on a determination of disability or to consider an appeal of an adverse benefit determination shall be suspended from the date any notification of extension is sent to the claimant or appellant until such individual fulfills such request for additional information.

6.4 Claims Procedure for Benefits Other Than Health Benefits or Those Based on Determination of Disability.

(a) If the Welfare Program does not describe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA, or the Plan Administrator determines that the procedures described in Sections 6.2 or 6.3 with respect to a particular Welfare Program shall not apply, the claims procedure described in this Section shall apply with respect to such Welfare Program if the Welfare Program is subject to ERISA. If the Welfare Program is not subject to ERISA as determined by the Plan Administrator, then the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program shall supersede this procedure.

(b) If a Participant or former Participant asserts a right to any benefit under the Plan that the Participant has not received, the Participant or his or her authorized representative shall file a written claim for such benefit with the Plan Administrator. If the Plan Administrator wholly or partially denies such claim, it shall provide written or electronic notice to the claimant within a reasonable period of time, but not later than 90 days after receipt by the Plan Administrator of the claim, unless the Plan Administrator determines that special circumstances require an extension of time, not to exceed 90 days, for processing the claim. If the Plan Administrator determines that an extension of time is required, it shall provide the claimant with written notice of the extension before the end of the initial 90-day period. Such notice shall describe the special circumstances requiring the extension of time and specify the date by which the Plan Administrator expects to render a benefit determination. If the Plan Administrator wholly or partially denies a claim, it shall set forth in its benefit determination, which shall be written in a manner calculated to be understood by the claimant:

(i) the specific reasons for the denial of the claim;

(ii) specific reference(s) to pertinent provisions of the Plan on which the adverse benefit determination is based;

(iii) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;

(iv) an explanation of the Plan's claims review procedure, including the time limits applicable under such procedure; and

(v) a statement that the claimant has the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

(c) A Participant or former Participant whose claim for benefits is denied may request a full and fair review of the adverse benefit determination within 60 days after notification of the adverse benefit determination by the Plan Administrator. The Participant or former Participant:

(i) shall be provided a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination;

(ii) shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim; and

(iii) may submit written comments, documents, records and other information relating to the claim to the Plan Administrator for review.

(d) Subject to Department of Labor Regulation 29 C.F.R. § 2560.503-1(i)(1)(ii), a decision on review by the Plan Administrator shall be made within a reasonable period of time, but not later than 60 days after receipt by the Plan Administrator of a request for review, unless special circumstances (such as the need to hold a hearing) require an extension of time for processing, in which case the claimant shall be provided with written notice of the extension before the end of the initial 60-day period. Such notice shall describe the special circumstances requiring the extension and specify the date by which the Plan Administrator expects to render its decision. In no event shall the decision be rendered later than 120 days after receipt of the request for review.

(e) The Plan Administrator shall provide written or electronic notice of its decision with respect to the claimant's appeal which shall be written in a manner calculated to be understood by the claimant. If there is an adverse benefit determination on review, the Plan Administrator's decision shall include:

(i) the specific reasons for the adverse benefit determination;

(ii) specific reference(s) to pertinent provisions of the Plan on which the adverse benefit determination is based;

(iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;

(iv) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to receive information about any such procedures; and

(v) a statement that the claimant has the right to bring a civil action under Section 502(a) of ERISA following the adverse benefit determination on review.

6.5 Unclaimed Benefits. If, within one year after any amount becomes payable hereunder to a Participant, Spouse, Dependent or Beneficiary and the same shall not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care shall have been exercised by the Plan Administrator in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan.

6.6 Right of Subrogation.

(a) Definitions. For purposes of this Section, the following definitions shall apply:

(i) Award. "Award" means any amount paid to or on behalf of a Covered Individual, from a Third Party with respect to a Covered Individual's Illness, Injury or other loss regardless of whether such amount is received as a result of a judgment of a court of competent jurisdiction, settlement, compromise or otherwise and regardless of whether such amount is categorized as punitive, compensatory, reimbursement for medical expenses, or otherwise.

(ii) Covered Individual. "Covered Individual" includes the individual for whom benefits are paid by the Plan and his or her heirs, guardians, executors or other representatives.

(iii) Injury or Illness. "Injury" or "Illness" means such term as defined in each Welfare Program.

(iv) Reimbursement. "Reimbursement" means the Plan's right to recover any and all amounts paid for medical expenses from a Covered Individual who receives any award related to the Illness, Injury or other loss that resulted in the payment of such benefits by the Plan.

(v) Subrogation. "Subrogation" means the right of the Plan to be substituted in place of any Covered Individual with respect to that Covered Individual's lawful claim, demand, or right of action against a Third Party who may have wrongfully caused the Covered Individual's Injury, Illness or other loss that resulted in a payment of benefits by the Plan.

(vi) Third Party. "Third Party" includes, but is not limited to, any person or entity that caused, contributed to, or may be responsible for the Injury, Illness or other loss to the Covered Individual. Third Party shall include any party, such as an insurance company, that acquires or may acquire responsibility through the actions of such person or entity, and shall also include uninsured motorist coverage.

(b) Subrogation, Reimbursement and Benefit Offsets. For any and all benefits paid by the Plan to or on behalf of a Covered Individual by reason of Illness, Injury or other loss, the Plan shall have the following rights:

(i) Subrogation to any and all rights of recovery the Covered Individual may have arising from such Injury, Illness or other loss;

(ii) Reimbursement for the amount of any and all benefits paid to or on behalf of the Covered Individual by reason of Injury, Illness or other loss with respect to which the Plan has a right to Subrogation pursuant to paragraph (i) above from any Award arising out of such Injury, Illness or other loss; and

(iii) Benefit offsets of future claims payable by the Plan on behalf of the Covered Individual or members of such Covered Individual's immediate family to recover any and all amounts paid to or on behalf of the Covered Individual by reason of such Illness, Injury or other loss with respect to which the Plan has a right to Subrogation pursuant to paragraph (i) and a right to Reimbursement pursuant to paragraph (ii) but which have not, for any reason whatsoever, been reimbursed to or recovered by the Plan.

The Plan's subrogation/reimbursement/benefit offset rights (herein referred to collectively as "Recovery Rights") shall include the right to recover the amount due and owing to the Plan pursuant to its Recovery Rights from any Award paid to or for the benefit of the Covered Individual. The Plan does not recognize the "make whole" rule and a Covered Individual may not be whole after the Plan's Recovery Rights are satisfied.

(c) Payment Prior to Determination of Responsibility of a Third Party. The Plan does not cover nor is it liable for any expenses for services or supplies incurred by a Covered Individual for any Illness, Injury or other loss which a Third Party caused, contributed to or may be responsible for to the extent that the Covered Individual receives any Award from any Third Party. However, subject to the terms and conditions of this Section, the Plan will, after receipt of an executed reimbursement/subrogation/assignment agreement on such form as the Plan Administrator may require, make advance payment of benefits in accordance with the terms of the Plan, until an Award is paid to or for the benefit of the Covered Individual by a Third Party with respect to such Illness, Injury or loss. The terms and provisions of such reimbursement/subrogation/assignment agreement are incorporated herein by reference and any such agreement shall constitute a part of the Plan.

By accepting an advance payment of benefits from the Plan, the Covered Individual(s) jointly and severally agree that:

(i) the Plan has a priority lien against any Award paid to or on behalf of the Covered Individual to assure that Reimbursement is promptly made; and

(ii) the Plan will be subrogated to such Covered Individual's right of recovery from any Third Party to the extent of the Plan's advance payment of benefits; and

(iii) such Covered Individual(s) will, jointly and severally, reimburse the Plan out of any and all Awards paid or payable to such Covered Individual(s) by any Third Party to the extent of the Plan's advance payment of benefits for claims related to the Illness, Injury or other loss; and

(iv) such Covered Individual(s) will assign to the Plan all of their right, title and interest in and to any Award paid to or on their behalf by any Third Party to the extent of any advance payment of benefits made or to be made in accordance with the terms of the Plan.

The Plan's Recovery Rights include but are not limited to all claims, demands, actions and rights of recovery of all Covered Individuals against any Third Party, including any workers' compensation insurer or governmental agency, and will apply to the extent of any and all advance payment of benefits made or to be made by the Plan.

(d) Recovery Actions. The Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its Recovery Rights, and may try or settle any such action or proceeding in the name of and with the full cooperation of the Covered Individual. However, in doing so, the Plan will not represent, or provide legal representation for, any Covered Individual with respect to such Covered Individual's damages to the extent those damages exceed any advance payment of benefits made or to be made in accordance with the terms of this Plan.

The Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any Covered Individual against any Third Party on account of any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual's Illness, Injury or other loss that resulted in any advance payment of benefits by the Plan.

(e) Reimbursement/Subrogation/Assignment Agreement. Prior to the advance payment of benefits for which a Third Party may be responsible, the Covered Individual on whose behalf an advance payment of benefits may be payable must execute and deliver any and all agreements, instruments and papers requested by or on behalf of the Plan including an executed reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require. The failure of a Covered Individual to execute any such reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require, for any reason, shall not waive, compromise, diminish, release, or otherwise prejudice

any of the Plan's Recovery Rights if the Plan, at its discretion, makes an advance payment of benefits for any reason in the absence of a reimbursement/subrogation/assignment agreement.

(f) Administrative Procedure. The Plan's standard administrative procedure will be to determine whether a Third Party could be held liable for a claim. Claims will not be paid until this determination is made. If it is determined that the claim may be the responsibility of a Third Party for any reason, the Plan will not process any claims without a properly signed reimbursement/subrogation/assignment agreement as described in this Section.

(g) Cooperation with the Plan by All Covered Individuals. By accepting an advance payment of benefits, the Covered Individual agrees not to do anything that will waive, compromise, diminish, release or otherwise prejudice the Plan's Recovery Rights and to do whatever is necessary to protect the Plan's Recovery Rights.

By accepting an advance payment for benefits the Covered Individual agrees to notify and consult with the Plan Administrator or its designee before:

(i) starting any legal action or administrative proceeding against a Third Party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual's Illness, Injury or other loss that resulted in the Plan's advance payment for benefits; or

(ii) entering into any settlement agreement with a Third Party that may be related to any actions by the Third Party that may have caused or contributed to the Covered Individual's Illness, Injury or other loss that resulted in the Plan's advance payment for benefits related to such Illness, Injury or other loss.

Furthermore, by accepting an advance payment of benefits, the Covered Individual agrees to keep the Plan Administrator or its designee informed of all material developments with respect to all such claims, actions or proceedings.

The Plan's Recovery Rights are Plan assets. The Plan or its designee may institute a lawsuit against a Covered Individual if such Covered Individual does not adequately protect the Plan's Recovery Rights.

(h) All Recovered Proceeds Are to be Applied to Reimburse the Plan. By accepting an advance payment of benefits for an Illness, Injury or other loss, the Covered Individual agrees to reimburse the Plan for all such advances from any Award paid or payable to or on behalf of such Covered Individual by any Third Party. In such event, the Plan must be fully reimbursed within 31 days or the Covered Individual will be liable for interest and all costs of collection, including reasonable attorney's fees.

If a Covered Individual fails to reimburse the Plan as required by this Section, the Plan may apply any future claims for benefits that may become payable on behalf of such Covered Individual or any member of such Covered Individual's immediate family to the amount not reimbursed.

Notwithstanding anything contained in the Plan to the contrary, the Plan will not pay future benefits for claims related to an Illness, Injury or other loss with respect to which an Award was paid to or on behalf of a Covered Individual unless the Plan Administrator determines that the Award was reasonable and the subsequent claims were not recognized in the Award.

(i) Pre-Emption of State Law. To the extent that this Plan is a self-insured employee welfare benefit plan, ERISA preempts any state law purporting to limit, restrict or otherwise alter the Plan's Recovery Rights.

(j) No-Fault Insurance Coverage. Notwithstanding anything contained in the Plan to the contrary, if a Covered Individual is required to have no-fault automobile insurance coverage, the automobile no-fault insurance carrier will initially be liable for any and all expenses paid by this Plan up to the greater of:

(i) the maximum amount of basic reparation benefit required by applicable law, or

(ii) the maximum amount of the applicable no-fault insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of this Plan in which the Covered Individual is provided coverage. Before related claims will be paid through the Plan, the Covered Individual will be required to sign a reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require.

If the Covered Individual fails to secure no-fault insurance as required by state law, the Covered Individual is considered as being self-insured and must pay the amount of any and all expenses paid by the Plan for any and all Covered Individuals arising out of the accident.

(k) Refund of Overpayment of Benefits – Right of Recovery. If the Plan pays benefits for expenses incurred on account of a Covered Individual, the Covered Individual or any other person or organization that was paid must make a refund to the Plan if:

(i) all or some of the expenses were not paid, or did not legally have to be paid, by the Covered Individual;

(ii) all or some of the payment made by the Plan exceeds the benefits under the Plan; or

(iii) all or some of the expenses were recovered from or paid by a source other than this Plan, including another plan to which this Plan has secondary liability under the Coordination of Benefits provisions.

This may include payments made as a result of claims against a Third Party for negligence, intentional or otherwise wrongful acts or omissions. The refund shall equal the amount the Plan paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Plan paid.

If a Covered Individual or any person or organization that was paid does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

## ARTICLE VII

## Special Compliance Provisions

7.1 Use and Disclosure of Protected Health Information. (a) Any health plan under the Plan shall use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For purposes of this Section, health plan shall have the meaning as defined in HIPAA. Specifically, any health plan shall use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

(b) Health Care Treatment. Health care treatment means the provision, coordination or management of health care and related services by one or more health care providers. It also includes coordination or management of health care by a health provider and a third party and consultation or referrals between one health care provider and another.

(c) Payment. Payment includes activities undertaken by any health plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits, or to obtain or provide reimbursement for the provision of health care, that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(i) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);

(ii) coordination of benefits;

(iii) adjudication of health claims (including appeals and other payment disputes);

(iv) subrogation of health claims;

(v) establishing employee contributions;

(vi) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(vii) billing, collection activities and related health care data processing;

(viii) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(ix) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(x) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(xi) utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(xii) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(xiii) reimbursement to a health plan.

(d) Health Care Operations. Health care operations include, but are not limited to, the following activities:

(i) quality assessment;

(ii) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives and related functions that do not include treatment;

(iii) rating provider and health plan performance, including accreditation, certification, licensing or credentialing activities;

(iv) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(v) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(vi) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the health plan, including formulary development or improvement of payment methods or coverage policies; and

(vii) business management and general administrative activities of the health plan, including, but not limited to:

(A) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

(B) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers, provided that protected health information is not disclosed to such policyholder, plan sponsor, or customer;

(C) resolution of internal grievances; and

(D) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

(e) A health plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or other covered individual. With an authorization, a health plan shall disclose PHI to pension plans, disability plans, reciprocal benefit plans, and workers' compensation insurers, for purposes related to administration of the health plan.

(f) A health plan shall disclose PHI to the Employer only upon receipt of a certification from the Employer that the health plan documents have been amended to incorporate the following provisions and that the Employer agrees to:

(i) not use or further disclose PHI other than as permitted or required by the health plan document or as required by law;

(ii) ensure that any agents, including subcontractors, to whom the Employer provides PHI received from a health plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(iii) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

(iv) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

(v) report to the health plan's designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;

(vi) make PHI available to an individual in accordance with HIPAA's access requirements;

(vii) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(viii) make available the information required to provide an accounting of disclosures;

(ix) make the Employer's internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services for the purposes of determining the health plan's compliance with HIPAA;

(x) ensure that adequate separation between the health plan and the Employer is established as required by HIPAA; and

(xi) if feasible, return or destroy all PHI received from the health plan that the Employer maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible).

(g) Only those employees or classes of employees identified in the Plan's privacy policies and procedures may have access to and use and disclose PHI for plan administration functions that the Employer performs for the health plan. If such individuals do not comply with this health plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

(h) Security. The Employer shall implement security measures with respect to PHI to the extent of and in accordance with the security rules implemented by HIPAA. Specifically, the Employer shall:

(i) implement administrative, physical and technical safeguards that will reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the plan;

(ii) ensure the adequate separation between the Plan and the Employer is supported by reasonable and appropriate security measures;

(iii) ensure that any agent, including a subcontractor, to whom it provides information agrees to implement reasonable and appropriate security measures to protect the information (e.g., in the event the Employer provides information to the broker for renewal bids); and

(iv) report to the Plan any security incident of which it becomes aware.

7.2 Special Enrollment Rights. (a) In accordance with the HIPAA special enrollment rules, if an eligible Employee declines coverage in a group health plan for himself or herself and/or the Employee's Spouse and Dependents because of other health insurance coverage, they may be able to enroll in the Plan's group health coverage upon loss of eligibility for the other coverage, provided that the Participant requests enrollment within 30 days after the other coverage ends.

If a Participant gains a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and the Participant's Spouse and Dependents in the group health Welfare Program provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

(b) Employees, Spouses and Dependents who are eligible but not enrolled in a group health plan listed in Appendix A may enroll when:

(i) The Employee's, Spouse's or Dependent's Medicaid or Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility and the eligible Employee requests coverage under a group health plan listed in Appendix A within 60 days after the termination, or

(ii) The Employee, Spouse or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP and the eligible Employee requests coverage under a group health plan listed in Appendix A within 60 days after eligibility is determined.

The special enrollment rules of this Section 7.2 do not apply to limited scope dental or vision benefits or certain health care flexible spending accounts (e.g., health care spending accounts that limit benefits to employee salary reduction amounts).

7.3 Qualified Medical Child Support Orders. A qualified medical child support order ("QMCSO") is an order made pursuant to state domestic relations law by a court or a state agency authorized under state law to issue child support orders which requires a group health plan to provide a child or children of an Employee with health insurance coverage. The Plan Administrator shall comply with the terms of any QMCSO it receives, and shall:

(a) Establish reasonable procedures to determine whether a medical child support order is a QMCSO as defined under Section 609 of ERISA (these procedures are available, free of charge, to Participants and Beneficiaries upon request to the Plan Administrator);

(b) Promptly notify the Participant and any alternate recipient of the receipt of a medical child support order, and the group health plan's procedures for determining whether the medical child support order is a QMCSO; and

(c) Within a reasonable period of time after receipt of such order, determine whether such order is a QMCSO and notify the Participant and each alternate recipient of such determination.

7.4 State Medicaid Programs. Eligibility for coverage or enrollment in a state Medicaid Program shall not impact an Employee's, Spouse's or Dependent's eligibility for health coverage or health benefits under the Plan.

7.5 Coverage During FMLA Leave. A Participant on a leave of absence that qualifies as leave under the Family and Medical Leave Act of 1993 ("FMLA") may continue to receive group health plan coverage under this Plan during such leave along with his or her eligible Spouse and Dependents as if such participant did not experience an interruption in active employment until the end of such FMLA leave period, or, if earlier, the date the Participant gives notice that he or she does not intend to return to work at the end of the FMLA period. The Participant must make any required contributions for group health plan coverage during such period in such time and manner as the Plan Administrator may require under applicable federal regulations and in accordance with the terms of any applicable Code Section 125 cafeteria plan sponsored by the Employer.

If a Participant does not continue group health coverage or other types of coverage but returns to work before the expiration of FMLA leave, he or she must be reinstated in his or her benefit coverage, including group health care coverage, at the same level and under the same conditions as if the leave had not occurred.

7.6 Special Rules for Maternity and Infant Coverage. Any health plan available under the Plan shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The attending provider or physician, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Notwithstanding the foregoing, the health plan and issuers may not require that a provider obtain authorization from the health plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

7.7 Special Rule for Women's Health. If a health benefit plan available under the Plan provides medical and surgical benefits for mastectomy procedures, it shall provide coverage for reconstructive surgery following mastectomies. This expanded coverage includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the health benefit plan or coverage.

7.8 Military Leave.

A Participant's right to elect continued participation in a group health plan available under this Plan for himself or herself, the Participant's Spouse and Dependents during a leave of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

(a) Participants may elect to continue group health plan coverage under the Plan for a period of time that is the lesser of:

(i) the 24-month period beginning on the Participant's first day of military leave, or

(ii) the period beginning on the Participant's first day of military leave and ending on the date the Participant fails to return from military leave or apply for re-employment as required under USERRA.

(b) If a Participant's absence for military duty is less than 31 days, the Participant will be required to pay the regular employee share of the cost for group health plan coverage. If the Participant's absence is for 31 or more days, the Participant will be required to pay not more than 102% of the full cost of the group health plan coverage (and the Participant's Spouse and Dependents) under the Plan.

(c) USERRA continuation group health plan coverage is considered alternative group health plan coverage for purposes of COBRA. Therefore, if a Participant elects USERRA continuation coverage, COBRA continuation group health plan coverage shall not be available.

(d) Participants returning from military leave shall be reinstated upon re-employment, and any exclusion or waiting period shall not be imposed if such exclusion or waiting period would not have been imposed had the Participant's coverage not been terminated due to military leave. This paragraph shall not apply to illnesses or injuries determined by the Secretary of Veteran's Affairs or his or her representative to have been incurred in, or aggravated during, the performance of military service.

(e) In no event shall benefits available under this Plan during a period of USERRA qualified military leave be less generous than those benefits available during other comparable employer approved leave periods (e.g., family and medical leave).

7.9 COBRA.

(a) Legal Rights to Continuation Coverage Under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). The Employer, to the extent required by law, shall offer a Participant and/or a Spouse or dependent child who, as a result of a "qualifying event," becomes otherwise ineligible to participate in a group health plan, as defined in Section 607(l) of ERISA, under the Plan the opportunity to temporarily extend coverage under such group health plan at group rates. A domestic partner shall not be considered a Spouse for COBRA purposes

and therefore shall not be entitled to COBRA continuation coverage unless otherwise required under applicable law. However, the Employer may, solely in its own discretion, and solely in the manner it determines, provide continuation coverage to domestic partners who are Plan beneficiaries.

(b) Qualifying Events.

(i) A Participant who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following qualifying events, shall be eligible for COBRA continuation coverage.

(A) A reduction of the Participant's hours of employment;

(B) The Participant's voluntary or involuntary termination of employment for reasons other than gross misconduct; or

(C) Upon the Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is a retired employee.

(ii) A Spouse who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following qualifying events, shall be eligible for COBRA continuation coverage.

(A) The Participant's voluntary or involuntary termination of employment for reasons other than gross misconduct, or reduction of hours of employment;

(B) The death of the Participant;

(C) The divorce or legal separation of the Participant and Spouse;

(D) Enrollment in Medicare (Part A or B) by the Participant; or

(E) The Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is retired.

(iii) A Participant's dependent child who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following events, shall be entitled to COBRA continuation coverage.

(A) The loss of Dependent status under the group health plan;

(B) The Participant's voluntary or involuntary termination for reasons other than gross misconduct, or the Participant's reduction of hours of employment;

(C) The death of the Participant;

(D) The divorce or legal separation of the Participant and Spouse;

(E) Enrollment in Medicare (Part A or B) by the Participant; or

(F) The Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is retired.

(c) Qualified Beneficiary. A Qualified Beneficiary is a Participant, Spouse, or dependent child who on the day before a qualifying event is covered under a group health plan available under the Plan. Qualified Beneficiary includes children born to, adopted by, or placed for adoption with the Participant during his or her COBRA continuation coverage period. Such child's coverage period shall be determined according to the date that the Participant's COBRA continuation coverage period began. A domestic partner is not a Qualified Beneficiary for COBRA purposes and therefore shall not be entitled to COBRA continuation coverage as described in this Article VII unless otherwise required under applicable law.

(d) Notices. A Qualified Beneficiary who wishes to receive COBRA continuation coverage as a result of divorce or legal separation must notify the Plan Administrator within 60 days after such divorce or legal separation. A Qualified Beneficiary who wishes to receive COBRA continuation coverage as a result of the loss of Dependent status under the group health plan available under the Plan must notify the Plan Administrator within 60 days of such loss of Dependent status.

The Qualified Beneficiary shall be notified of his or her right to elect continuation coverage and the cost to do so. Continuation coverage must be elected within 60 days after the later of the date coverage under the group health plan available under the Plan ceases or the date the Qualified Beneficiary is notified of the right to elect continuation coverage.

If the Qualified Beneficiary does not elect continuation coverage, coverage under the group health plan available under the Plan shall cease. If the Qualified Beneficiary chooses continuation coverage, such group health plan shall provide coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during an open enrollment period.

(e) Cost. The Qualified Beneficiary must pay the full cost of such coverage to the Plan for a similarly situated active employee. The Plan may charge a 2% administrative fee. The COBRA premium may increase to 150% of the total premium during a disability extension as described in paragraph (f)(iv).

(f) Maximum Continuation Period.

(i) A Qualified Beneficiary who loses group health plan coverage available under the Plan as a result of the death of the Participant, the Participant's eligibility for Medicare, divorce, legal separation or loss of Dependent status under such group health plan and elects COBRA continuation coverage shall be entitled to receive up to 36 months of COBRA continuation coverage beginning on the date on which the qualifying event occurred.

(ii) A Qualified Beneficiary who loses group health plan coverage as a result of the Participant's termination of employment or reduction of hours and elects COBRA continuation coverage shall be entitled to receive up to 18 months of COBRA continuation coverage beginning on the date on which the qualifying event occurred. If a second qualifying event occurs during such 18-month period, the COBRA continuation coverage period may be extended by an additional 18 months for each Qualified Beneficiary (other than a covered Employee). The Qualified Beneficiary must notify the Plan Administrator within 60 days of a second qualifying event to receive the additional 18 months of continuation coverage. A second qualifying event is an event that occurs during the initial 18-month period that would have resulted in a loss of group health plan coverage for the Qualified Beneficiary in the absence of the first qualifying event. In no event, however, shall any Qualified Beneficiary's COBRA continuation coverage period exceed 36 months.

(iii) A Qualified Beneficiary (other than the Participant) who loses group health plan coverage as a result of the Participant’s termination of employment or reduction of hours and such event occurs within 18 months following the Participant’s enrollment in Medicare, shall be entitled to receive up to 36 months of COBRA continuation coverage beginning on the date the Participant enrolled in Medicare.

(iv) If a qualifying event occurs that is the Participant's termination of employment or reduction of hours, any Qualified Beneficiary who is deemed to have been disabled, as determined by the Social Security Administration, at any time during the first 60 days of COBRA continuation coverage shall be eligible to extend the COBRA continuation coverage period to 29 months. In the case of a child born to or adopted by a Participant during the Participant's COBRA continuation coverage period, such 60-day period will begin from the date of birth or placement of adoption. Such extension shall apply to the Qualified Beneficiary's covered family members. Such Qualified Beneficiary must notify the Plan Administrator of the disability in writing within 60 days of the date of the Social Security Administration determination and before the end of the 18-month continuation coverage period. A Qualified Beneficiary receiving extended COBRA continuation coverage due to disability must inform the Plan Administrator within 30 days of receiving a final determination that he or she is no longer disabled.

(v) In the case of a qualifying event that is the bankruptcy of the Employer, the maximum coverage period for a Qualified Beneficiary who is the retired covered employee ends on the date of the retired covered employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse, or dependent child of the

retired covered employee ends on the earlier of—(A) The date of the Qualified Beneficiary's death; or (B) The date that is 36 months after the death of the retired covered employee.

(g) Termination of COBRA Continuation Coverage. COBRA continuation coverage shall cease upon the occurrence of any of the following events:

(i) The Employer ceases to provide group health plan coverage to any of its employees;

(ii) The Qualified Beneficiary fails to pay the premium or required contribution within 30 days after its due date;

(iii) The Qualified Beneficiary becomes covered, after the date of the COBRA continuation coverage election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such Qualified Beneficiary (other than an exclusion or limitation that may be disregarded under the law);

(iv) The Qualified Beneficiary becomes enrolled in Medicare after the date of the COBRA continuation coverage election;

(v) The Qualified Beneficiary has extended COBRA continuation coverage due to a disability and is subsequently determined by the Social Security Administration to be no longer disabled;

(vi) The maximum required COBRA continuation coverage period expires; or

(vii) For cause, such as fraudulent claim submission, that would result in termination of coverage for a similarly situated active employee.

(h) Second Election Period. A Participant and his or her covered family members may be eligible to elect continuation coverage during a second election period if such Participant:

(i) is receiving trade adjustment assistance benefits under the Trade Act of 2002 (or would be eligible to receive trade adjustment assistance benefits but has not exhausted unemployment benefits);

(ii) lost health coverage due to termination of employment that resulted in eligibility for trade adjustment assistance benefits under the Trade Act of 2002; and

(iii) did not elect COBRA continuation coverage during the initial COBRA election period.

The second election period is the 60-day period beginning on the first day of the month in which the Participant becomes eligible for such second election period, but only if the election is within the six-month period after the Participant initially lost coverage. COBRA continuation coverage begins on the first day of the second election period. Such coverage is not retroactive to the date the Participant initially lost coverage.

7.10 Genetic Information Nondiscrimination Act of 2008 ("GINA"). (a) Unless otherwise permitted, the Employer may not request or require any genetic information from an Employee or family member of the Employee.

(b) "Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

(c) The Employer shall not request any genetic information when requesting health-related information. However, with respect to any wellness program available under the Plan, the Employer may request, but may not require, an Employee to provide genetic information in accordance with Equal Employment Opportunity Commission regulations.

(d) The Employer will not request, require or purchase genetic information in violation of GINA. If the Employer intentionally or unintentionally obtains genetic information pertaining to an Employee or a family member of the Employee, the Employer will not use such genetic information in violation of GINA. Any genetic information received by the Employer that pertains to an Employee or a family member of the Employee, shall be maintained on forms and in medical files that are separate from personnel files, and shall be treated as confidential medical records.

7.11 Health-Related Factors. The group health plan will not discriminate against any participant or dependent in terms of eligibility to participate in the plan based on a health-related factor. In addition, benefits provided under the group health plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The group health plan may (i) limit or exclude benefits that are experimental or are not medically necessary and (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals, and are not just directed at an individual based on a health-related factor.

7.12 Mental Health Parity Act. The group health plan must generally comply with the provisions of the Mental Health Parity and Addiction Equity Act of 2008, including that the group health plan's financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) that are applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

## ARTICLE VIII

## Amendment and Termination

8.1 Amendment. The Employer has the right to amend the Plan at any time, including the right to amend any of the Welfare Programs or to transfer any Welfare Program from the Plan into a separate, related plan, at the direction of an authorized officer of the Employer or an authorized designee.

8.2 Termination. The Employer has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Employer is not and shall not be under any obligation or liability whatsoever to maintain the Plan (or any Welfare Program) for any given length of time and may, in its sole and absolute discretion, discontinue or terminate the Plan, in whole or in part, at any time, including termination of any one or more of the Welfare Programs, at the direction of an authorized officer of the Employer or an authorized designee.

## ARTICLE IX

## Miscellaneous

9.1 Exclusive Benefit. This Plan has been established for the exclusive benefit of Participants, Spouses, Dependents or Beneficiaries, and except as otherwise provided herein, all contributions under the Plan may be used only for such purpose.

9.2 Non-Alienation of Benefits. No benefit, right or interest of any Participant, Spouse, Dependent or Beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or, in the case of assignments, as permitted under the terms of a Welfare Program.

9.3 Limitation of Rights. Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed as to:

(a) give any person any legal or equitable right against the Employer (or Participating Employer) except as expressly provided herein or required by law, or

(b) create a contract of employment with any Employee, obligate the Employer (or Participating Employer) to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way.

9.4 Governing Laws and Jurisdiction and Venue. The Plan shall be construed and enforced according to the laws of the state of California to the extent not preempted by federal law which shall otherwise control. Exclusive jurisdiction and venue of all disputes arising out of

or relating to this Plan or any of the Welfare Programs shall be in any court of appropriate jurisdiction in the state of California.

9.5 Severability. If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.

9.6 Construction. The captions contained herein are inserted only as a matter of convenience and reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

9.7 Titles. The titles of the Articles and Sections hereof are included for convenience only and shall not be construed as part of the Plan or in any respect affecting or modifying its provisions. Such words in this Plan as "herein," "hereinafter," "hereof" and "hereunder" refer to this instrument as a whole and not merely to the subdivision in which said words appear.

9.8 Expenses. Subject to the terms of the Welfare Programs, any expenses incurred in the administration of the Plan shall be paid by the Plan and/or by the Employer, according to the Employer's determination.

## ARTICLE X

## Participating Employers

10.1 Adoption of the Plan. This Plan may be adopted by a Participating Employer, provided that such adoption is with the approval of the Employer. Such adoption shall be by resolution of the Participating Employer's governing body.

10.2 Administration. As a condition to adopting the Plan, and except as otherwise provided herein, each Participating Employer shall be deemed to have authorized the Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Plan Administrator.

10.3 Termination of Participation. Each Participating Employer may cease to participate in the Plan or in any Welfare Program with respect to its Employees or former Employees by resolution of its governing body.

## ARTICLE XI

## Effective Date

The effective date of this amended and restated Plan is January 01, 2025.

* * * * *

IN WITNESS WHEREOF, the Employer has caused this instrument to be duly executed in its name and on its behalf as of the date set forth below.

El Camino Hospital

Signed by:
By: Deanna W. Dudley
3D4711B8125040E...
Date: 12/23/2025

ATTEST:

_____

APPENDIX A
EL CAMINO HOSPITAL HEALTH & WELFARE PLAN

WELFARE PROGRAMS

The following Welfare Programs shall be treated as part of the Plan pursuant to Section 2.15 and as defined in Section 2.19:

**Welfare Programs**
**Group Medical Plans**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | Aetna Inc. |
| Contract Number: | 0181066 |
| Address: | 151 Farmington Avenue<br>Hartford, Connecticut 06156<br>(833) 576-2491<br>https://www.aetna.com |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Prescription Drug Plan**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | OptumRx, Inc. |
| Contract Number: | HT1ELCH24 |
| Address: | 11000 Optum Circle<br>Eden Prairie, Minnesota 55344<br>(844) 813-7269<br>https://www.optumrx.com |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Group Medical Plan (Hawaii Only)**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | UHA Health Insurance |
| Contract Number: | 0041B0001 |
| Address: | 700 Bishop Street, Suite 300<br>Honolulu, Hawaii 96813<br>(808) 532-4000<br>https://www.uhahealth.com |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Group Retiree Medical Plan**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | UnitedHealthcare |
| Contract Number: | 13606 |
| Address: | PO Box 30770<br>Salt Lake City, Utah 84130<br>(800) 457-8506<br>https://retiree.uhc.com |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Group Dental Plan (DHMO)**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | Delta Dental of California |
| Contract Number: | 71572 |
| Address: | PO Box 1803<br>Alpharetta, Georgia 30023<br>(800) 422-4234<br>https://www1.deltadentalins.com |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Group Dental Plans (PPO)**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | Metropolitan Life Insurance Company |
| Contract Number: | 302572 |
| Address: | 200 Park Avenue<br>New York, New York 10166<br>(800) 942-0854<br>https://www.metlife.com |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Group Vision Plans (Standard and Enhanced)**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | Vision Service Plan (VSP) |
| Contract Number: | 12154060 |
| Address: | 3333 Quality Drive<br>Ranch Cordova, California 95670<br>(800) 877-7195<br>https://www.vsp.com |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Health Care Flexible Spending Account**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | Workterra |
| Address: | PO Box 11657<br>Pleasanton, California 94588<br>(888) 327-2770<br>https://businessolver.com/workterra |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Group Basic Life Insurance Plan**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | The Hartford |
| Contract Number: | 402989 |
| Address: | PO Box 2999<br>Hartford, Connecticut 06104<br>(877) 778-1383<br>https://www.thehartford.com/employee-benefits/employees |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Voluntary Life Insurance Plan**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | The Hartford<br>GL153180 |
| Contract Number: | PO Box 2999 |
| Address: | Hartford, Connecticut 06104<br>(877) 778-1383<br>https://www.thehartford.com/employee-benefits/employees |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Accidental Death and Dismemberment Insurance Plan**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | The Hartford<br>ADDS08296 |
| Contract Number: | PO Box 2999 |
| Address: | Hartford, Connecticut 06104<br>(877) 778-1383<br>https://www.thehartford.com/employee-benefits/employees |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Group Long-Term Disability Plan**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | The Hartford<br>402989 |
| Contract Number: | PO Box 2999 |
| Address: | Hartford, Connecticut 06104<br>(877) 778-1383<br>https://www.thehartford.com/employee-benefits/employees |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Voluntary Accident and Hospital Indemnity Plans**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | Metropolitan Life Insurance Company<br>302572 |
| Contract Number: | 200 Park Avenue |
| Address: | New York, New York 10166<br>(800) 438-6388<br>https://www.metlife.com |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Voluntary Critical Illness Plan**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | Metropolitan Life Insurance Company |
| Contract Number: | 302572 |
| Address: | 200 Park Avenue<br>New York, New York 10166<br>(800) 438-6388<br>https://www.metlife.com |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Employee Assistance Program Plan**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | Concern<br>El Camino |
| Contract Number: | 2490 Hospital Drive, Suite 310 |
| Address: | Mountain View, California 94040<br>(800) 344-4222<br>https://employees.concernhealth.com |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Voluntary Legal Services Plan**

| | |
|---|---|
| Carrier's or Program Administrator's Name: | Metropolitan Life Insurance Company |
| Contract Number: | 302572 |
| Address: | 200 Park Avenue<br>New York, New York 10166<br>(800) 438-6388<br>https://www.metlife.com |

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

# APPENDIX B
# EL CAMINO HOSPITAL HEALTH & WELFARE PLAN

## PARTICIPATING EMPLOYERS

In addition to El Camino Hospital, the following Participating Employers have adopted the Plan pursuant to Section 10.1:

El Camino Healthcare District (ECHD)
Concern

There are no other employers participating in the Plan.